Rocky Mountain Physical Therapy

Patient Intake Form

Patient Information

Name: _____

Address:_____

City: _____ State_____ Zip_____

Gender □Female □Male

Employer:_____

Is this visit auto injury related? □ YES □ NO
Date of auto injury _____
Is this visit work injury related? □ YES □ NO
Date of work injury _____
Is your case in litigation? □ YES □ NO

Home Phone ( ) _____
Work Phone ( ) _____
Cell Phone ( ) _____

e-mail address _____
Emergency contact: _____

Date of Birth _____(required by insurance)

SSN: _____

Marital status □ Single □ Married □ Other

Referring provider_____

Referring provider phone number ( ) _____

Insurance Information

Insurance Co. Name: _____

Claims address _____

City: _____ State_____ Zip_____

Adjusters name/phone _____

ID # _____

Group # _____

Phone ( ) _____

Auto/Work comp claim # _____

Please read following agreements and authorizations to release medical information and sign below:
I authorize the release of any medical information necessary to process my claim.

I, the undersigned agree, whether signing as agent, of the patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the amount be referred to an attorney for collections, I shall pay reasonable attorney fees.

I hereby assign payment directly to ***Rocky Mountain Physical Therapy & Sports Injury Center, Inc.*** for all medical services rendered. I understand that I am financially responsible for any charges not covered by this assignment.

I authorize ***Rocky Mountain Physical Therapy & Sports Injury Center, Inc.*** to furnish any necessary information concerning this injury/illness to any doctor/insurance directly involved in this injury/illness requesting this information.

If I miss a scheduled appointment or cancel an appointment with fewer than 24 hours notice, I understand I shall pay Rocky Mountain Physical Therapy & Sports Injury Center, Inc usual fee of $70.00. I understand my insurance carrier will not pay for cancelled or missed appointments. I further understand if I am more than 20 minutes late, my appointment may be considered cancelled and I m responsible for payment.

Consent for Treatment
I hereby consent to such treatment procedures and patient care, which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient of Rocky Mountain Physical Therapy & Sports Injury Center, Inc.

Signed_____(Parent and/or Insured Party) Date_____