

# High Peak Physical Therapy New Patient Intake Form

## Contact Information:

Name: (First)	(Last)	(MI)	Name you prefer:		
Address:	Apt #:	City:	State:	Zip:	
Email Address:	Cell phone:	Home phone:			
Birth Date: / /	Age:	Sex: M / F			
Employer:	(Full time / Part time/ Retired /Student)			Job Title:	
Are you working? Y / N	If no, is it because of your problem? Y / N		Are you on light duty? Y / N		
Emergency Contact: W	Emergency contact phone number:		Marital Status: M S D		
How did you hear about us? <input type="checkbox"/> Referring Physician <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other:					
Referring Physician:			Primary Care Physician:		
How do you prefer to be contacted and/or informed of upcoming appointments? Phone Email Appointment Cards					

## Insurance Information \*(Or you may bring your insurance card/paperwork with you on your initial visit):

Is this an auto accident case? Y / N			Is this a worker's compensation case? Y / N			Injury Date: / /		
If "Yes", please list claim #:			Adjuster Contact info:					
Primary Insurance:			ID#:		Group#:			
Insured name:			DOB: / /					
Relationship to insured:			Address (if different from above):					
Secondary Insurance:			ID#:		Group#:			

**Consent to Treatment:** I hereby authorize the licensed staff at **High Peak Physical Therapy** to examine and treat me for the injury I have been referred here for or referred myself to.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

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Patient's Certification, Authorization to Release Information and Payment Request

## Release of Medical Information

I hereby authorize the release of any necessary and pertinent information to my insurance company or their representative for the payment of my insurance claim for services rendered at High Peak Physical Therapy. If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, or if deemed advisable by the treating clinician, I consent to the release of my entire medical records maintained by the provider to those other providers. I also give consent for High Peak Physical Therapy to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. I agree, as part of this consent for payment operations, that High Peak Physical Therapy can disclose billing information to any identity of the calling person and the calling person provides my correct social security number or health plan number.

## Permission to Discuss Protected Health Information ("PHI") with Third Persons

I agree that the provider may discuss my PHI with any persons that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person(s). I also agree the provider may discuss my PHI with any employers who arrange pay, directly or indirectly, for my medical treatment.

## Permission to Discuss Health Information Regarding Minors

I agree that High Peak Physical Therapy may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents/stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI and that I have no right to receive this information.

## Assignment of Benefits

I authorize my insurance carrier to pay the claim the series rendered directly to the provider, namely High Peak Physical Therapy 13 Baywood Dr Queensbury NY 12804.

I authorize release of any information needed to act on this request, and request that payment of authorized benefits be made on my behalf

## Permission to Call and Leave Voice Mail/Data Messages/Electronic Mail Correspondence

I agree that High Peak Physical Therapy may call and leave a voice mail and/or data message at my home or other number I provide them, or correspond to the electronic mail address I provide them regarding medical appointments, billing, or payment issues, or other information related to treatment, payment or health care operations. I may choose a preferred method of contact and alert this to the provider/staff.

**Notice of Privacy Practices:** I am aware that, upon my request, I can receive a copy of "Notice of Privacy Practices" which sets forth this provider's privacy practices and my right regarding privacy of my PHI upon request

*I have received a paper copy of this notice. I make the following special requests for confidential communications:* \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

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## **Cancellation/No Show Policy, Agreement for Payment and Co-payment**

At High Peak Physical Therapy, we offer a unique physical therapy experience where there is a one on one approach and you will be seen by a doctor of physical therapy throughout your time here. Our goal is to provide the best possible care while are you here. To help us achieve this goal, please be aware that there is a \$20.00 charge for not showing up for your scheduled appointment, or for all cancellations with less than 24 hour notice. Please also be aware that any payments for self pay/co-payment are due at the time of the services rendered. I may also be responsible to any balances/co-insurances due after insurance payment is made. Please also be advised that it is your responsibility to notify us promptly of any changes in your insurance plan to allow accurate billing for services.

Please make it your responsibility to know the rules and limitations of your insurance plan. Office charges for those paying directly without insurance coverage are:

Initial examination: \$75

Each subsequent follow up visit (approx 45 minutes to 1 hour): \$50

If you are satisfied with the treatment you receive, please tell your physician, family, friends, and neighbors. If for some reason you are dissatisfied at all, please speak with us. Thank you for your understanding, and we look forward to providing you with the best care possible.

I have read and understand the above. I agree to the terms.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_