

TEXSTAR PHYSICAL THERAPY PATIENT INTAKE AND CONSENT FORM

Attachment B1.003A
Attachment M7.005C

Internal Use Only:	Account # <input style="width: 80%;" type="text"/>	Account Type <input style="width: 80%;" type="text"/>	Office # <input style="width: 80%;" type="text"/>
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First Name _____ MI _____ Last Name _____ Address _____ City _____ State _____ Zip _____ Responsible Party _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Relationship to Responsible Party _____ Employer _____ Address _____ City _____ State _____ Zip _____	Date of Injury/Onset _____ Today's Date _____ Date of Birth _____ Age _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W Home Phone _____ Work Phone _____ Cell Phone _____ Injury Area _____ Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No If Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other Nature of Accident _____ SS# _____ Occupation _____ Contact at Employer _____
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Referring Physician _____ Phone Number _____

Primary Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____	Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Second Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____	Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you recently received home health services? Yes No
 Are you receiving or have you recently received other therapy services? Yes No Please initial: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at TEXSTAR PHYSICAL THERAPY. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that TEXSTAR PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit TEXSTAR PHYSICAL THERAPY, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to TEXSTAR PHYSICAL THERAPY and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____