Personal Information

Name: _____ Nickname: _____

D.O.B: _____ /_____ /_____ Social Security #: _____-_____-_____

Gender: Male [ ] Female [ ] Gender Identity/Pronouns (optional): _____

Contact Information

Address: _____

Phone Numbers: (H)_____ (C)_____ (W)_____
Text message appointment reminders? YES [ ] NO [ ] (standard messaging rates apply)

Preferred Method of Contact: [ ] Home [ ] Cell [ ] Work [ ] Email: _____

Emergency Contact
Name: _____ Relation: _____ Phone number: _____

Referral Information
PCP/Referring Doctor: (name, address, phone number)
_____
_____
_____
_____

How did you hear about us? (Please select one):
[ ] Friend [ ] Family [ ] Doctor's Office [ ] Advertisement [ ] Other: _____

Quiet Corner Physical Therapy Consent To Treat
I hereby give Quiet Corner Physical Therapy permission for medical treatment, documentation, and billing of services rendered. Quiet Corner Physical Therapy will follow the direction of The Health Insurance Portability and Accountability Act (HIPAA). Medical Information may only be disseminated to insurance companies and other medical professionals that may be involved in my medical care.

Signature: _____ Date: _____
(Parental or Legal Guardian Signature required for children under the age of 18)

Quiet Corner Physical Therapy Waiver and Release of Liability
I hereby release Quiet Corner Physical Therapy and its employees from any responsibility or liability due to my participation in Physical Therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold those above responsible in the event of my occurring an injury or exacerbating any existing conditions. I have consulted with my physician to make sure that physical therapy is appropriate to participate in.

Signature: _____ Date: _____

Billing Information

☐ **Health Insurance:**

PRIMARY	SECONDARY
Company Name: _____	Company Name: _____
Phone Number:_____	Phone Number:_____
ID Number:_____	ID Number:_____
Group Number:_____	Group Number:_____
Name of Insured Party/Guarantor:	Name of Insured Party/Guarantor:
☐ Self ☐ Other:	☐ Self ☐ Other:
Name:_____	Name:_____
Male [ ] Female [ ] D.O.B _____	Male [ ] Female [ ] D.O.B. _____
Address: _____	Address: _____
_____	_____
_____	_____
Phone Number:_____	Phone Number:_____
Patient Relation:_____	Patient Relation:_____

☐ **Workers' Compensation:**

Employers' Name:_____

Employers' Address:_____

Employers' Phone Number:_____ Date of Injury: _____ /_____ /_____

Workers' Comp Insurance Company Name: _____

Adjusters' Name and Contact Information:_____

_____

☐ **Self-Pay:** I understand that the per visit, self-pay fee is $65.00 and is due at the time of visit.

Signature: _____

Quiet Corner Physical Therapy Financial Policy

It is the patients' responsibility to inquire about and understand their insurance as it pertains to physical therapy. The insurance information obtained from the patient and the insurance company will be used for copayments, deductibles, coinsurance, and other benefits. Copayments, deductibles, coinsurances, and visit limits are often estimates and are often based upon amount billed for treatment. If there is a discrepancy in the information given, Quiet Corner Physical Therapy will default to the benefits given by the insurance company. Quiet Corner Physical Therapy reserves the right to charge a $25 no show fee for missed visits or cancellations less than 2 hours before an appointment. Any remaining balances will be billed to the patient at the end of their treatment. By signing below, I agree to pay the owed balance billed by Quiet Corner Physical Therapy/A Plus Physical Therapy, LLC. And I certify that I understand and agree with Quiet Corner Physical Therapy's financial policies.

Print Name: _____ Signature: _____ Date: _____

(Parental or Legal Guardian Signature required for children under the age of 18)

Medical History

Print Name: _____

Medications: (use back of sheet if necessary)_____

Please list or provide a copy of any medical procedures that may impact your care:

_____

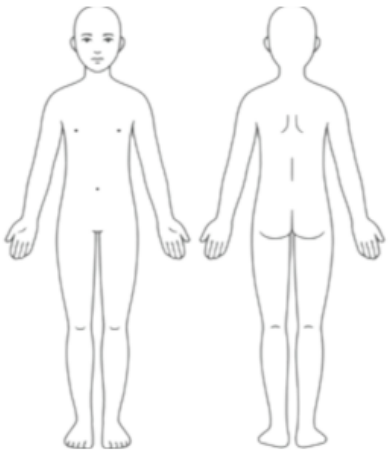
Any medical implants?	History of cancer?	Women: Are you pregnant?
YES / NO	YES / NO	YES / NO
Details:_____	Location/Type:_____	If "YES", How far along? _____

Please circle if you have or have previously had a history of:

Alzheimers/Dementia	Stroke	Fibromyalgia	History of DVT/Blood Clots
Cardiovascular Disease	Recent/Current Infection	Fracture or suspected fracture	Huntington's Disease
Spina Bifida	Diabetes Type I or II	High/Low Blood Pressure	Connective Tissue Disorders
Immunosuppression	Lupus/Lyme Disease	Muscular Dystrophy	Arthritis: Type: _____
Parkinson's Disease	Traumatic Brain Injury	Mental Health Issues	Other: _____

What are some of the things that you like to do/want to get back to doing?

What is your goal for Physical Therapy?



Area of Treatment:_____

Thank you for taking the time to complete this patient intake paperwork. Your information will be kept confidential in compliance with HIPAA (Health Insurance Portability and Accountability Act) regulations. Please ensure all the details provided are accurate and up-to-date. If you have any questions or need assistance, of not hesitate to ask a member of our staff. We look forward to serving you and supporting your health and wellness journey.

Signature: _____ Date: _____