PATIENT INTAKE FORM- PPO/MEDICARE/SELF PAY

First Name: ________________________________ Middle Initial: ______ Last Name: ____________________________

Nickname: ________________________________ Date of Birth: ____ / ____ / ______ SSN: _______________________

☐ Male ☐ Female Age:_______ Home Phone: ___________________________ Cell: ______________________

Residence Address: ____

Mailing Address (if different): ____

Emergency Contact: ______________________________ Phone: ______________________ Relationship: ___________

May we add you to our E- Newsletter? ☐ Yes ☐ No Email Address: _______________________________________

Would you like appointment reminders by text message? ☐ Yes ☐ No

Would you like appointment reminders by automatic phone call? ☐ Yes ☐ No

Primary Insurance

Name of Subscriber: _________________________ Date of Birth: ____ /____ /______ Relationship to Patient: _______

Phone: ______________________ SSN: _____ - _____ - ______ Insurance Company: ____________________________

ID #: ____ Group #/Name:_____________________________________

Is this injury work or auto related? ☐Yes ☐No Is there an attorney involved? ☐ Yes ☐No

Date of Injury: ____ / ____ / ______ Claim #: _______________________________________

If any of the above questions were marked "YES", please speak with the front desk to ensure proper billing.

Secondary Insurance ***If you have NO secondary insurance, initial here (_____)***

Name of Subscriber: _________________________ Date of Birth: ____ /____ /______ Relationship to Patient: _______

Phone: ______________________ SSN: _____ - _____ - ______ Insurance Company: ____________________________

ID #: ____ Group #/Name:_____________________________________

Financial Policy

I, undersigned have insurance coverage and assign directly to Walker Physical Therapy, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance including any amounts due at the time of service. I hereby authorize the medical provider to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

Signature: ____ Date: _________________ Relationship: _______________

Cancellation Policy

Your appointment at Walker Physical Therapy is scheduled with a licensed physical therapist, who has set aside time just for you. For optimal progression, it is imperative you make you scheduled appointments as prescribed by your physician. Walker Physical Therapy reserves the right to charge you $50.00 if you no show or do not cancel your appointment at least 24 hours in advance. However, we will take into account sicknesses and emergencies.

Signature: ____ Date: _________________ Relationship: _______________