PATIENT INTAKE FORM- WORK COMP/AUTO

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

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

☐ Male ☐ Female 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

Workers Compensation Carrier/Adjuster Information

Insurance Company: ____ SSN: ______ - ______ - _______

Adjuster's Name: ____________________________________ Adjuster's Number: _______________________________

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

Employer (At the time of injury): _____________________________________ Employer's Number: _________________

Employer's Address: ____

Cancellation/ Non-Compliance Policy

Your appointment at Walker Physical Therapy is scheduled with a licensed physical therapist for you. Your Therapist, physician, adjuster, and/or case manager all work together to assist with your return to full function in the workplace. In order for your treatment to have to have maximal effect and progress, all prescribed therapy visits must be attended. If for any reason, you are unable to attend an appointment, please call within 24 hours to re-schedule your appointment. Missed appointments may result in discontinuation workers' compensation benefits.

Signature: ____ Date: _________________ Relationship: _______________

Notice of Privacy Practices

I understand Walker Physical Therapy reserves the right to change the terms of their privacy practices and to make new notice provisions for all protected Health Information that it maintains. Patients may also get an updated copy, upon request, at any time from the staff at Walker Physical Therapy, Inc.

I hereby authorize information to be released only to the following person(s) listed below:

Name: ____ Relationship: _______________

Name: ____ Relationship: _______________

I acknowledge that I have either received a copy or read a posted copy of the privacy practices Walker Physical Therapy upholds and with full understanding as indicated by my own or my legal representative's signature below:

Signature: ____ Date: _____________________________