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INTAKE & CONSENT

NAME _____ M/F _____ AGE _____ DOB _____ SS # _____
Parent/Guardian if patient is a minor _____ DOB _____ SS # _____
MAILING ADDRESS _____
(Street) (City) (State) (Zip)
HOME PHONE # _____ E-MAIL ADDRESS _____
CELL PHONE # _____ WORK PHONE # _____ Preferred Contact Method? _____
OCCUPATION _____ EMPLOYER _____ Currently working? _____
PHYSICIAN _____ REFERRING PERSON _____
EMERGENCY CONTACT _____ RELATION _____ PHONE # _____

CLAIM INFORMATION: Self Pay (no insurance) Health Insurance Attorney/litigation
(please circle one) Workman's Compensation Auto Accident Other

A Copy of your insurance card(s) will be taken upon your first session

It is YOUR RESPONSIBILITY to know your Physical Therapy Benefits, CALL your insurance

WORKMAN'S COMP / AUTO ACCIDENT:

CLAIM MANAGER _____ PHONE # _____
CLAIM # _____ DATE OF INJURY/ACCIDENT _____

LITIGATION:

ATTORNEY'S NAME _____ PHONE # _____
ADDRESS _____ FAX # _____

I HEREBY CONSENT TO PHYSICAL THERAPY TREATMENT UNDER THE CARE OF KATHLEEN INGALLS, DPT & MINDFUL MOTION PHYSICAL THERAPY & WELLNESS, Inc. I agree to pay for all services rendered, whether they are covered or paid by my insurance or not. I authorize the release of medical records to ensure payment of claims. I understand that I am responsible for any deductible, co-payments, or denial from my insurance. I realize it is ultimately my responsibility to be sure payment is received by the office. In the event of MMPT contracting a collection agency for unreceived payment, all related costs will be my responsibility. MMPT has a 24 hour cancellation policy and I am responsible for the cost of services if I cancel within 24 hours of my scheduled session.

Patient/Parent/Guardian Signature _____ Date _____