AccelAbility® BALANCE & THERAPY

PATIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: **Patient's Legal Name:**

Nickname: **[ ] Male [ ] Female** **DOB:** **SSN:**

Mailing Address: **City/State/Zip:**

Main Phone: **Cell:** **Email:**

Primary Insurance: Secondary Insurance:

Primary Insured Name: Relationship to Patient:

Primary Insured DOB: Primary Insured SSN:

Employer: Occupation:

Address: Phone #:

Have you had ANY therapy in the **past 12 month?** [ ] PT [ ] OT [ ] Speech [ ] Chiropractic [ ] Cardiac/Pulmonary **or** [ ] No
If yes, when was it? _____ How many visits? _____ Was it at our clinic [ ] Yes [ ] No Was it for *same injury?* [ ] Yes [ ] No

Referring Physician: Phone:

Emergency Contact: Phone: Relationship:

WORK COMP OR MVA

Date of injury: _____Claim #_____

Insurance Company: _____Phone #: _____

Address: _____City/State/Zip: _____

Adjuster/Case Manager: _____Phone #: _____

Is an attorney involved? [ ] Yes [ ] No-Attorney Name/Phone #: _____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by AccelAbility Balance & Therapy. Further, I authorize AccelAbility Balance & Therapy to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by AccelAbility Balance & Therapy, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill. I agree to furnish proof if another party is responsible for the payment. I request any payments of authorized insurance benefits for me or on my behalf be paid directly to AccelAbility Balance & Therapy. I authorize AccelAbility Balance & Therapy to file my insurance with the insurance company listed above. I authorize the release of any medical information to AccelAbility Balance & Therapy to process this and any future claims. I understand that I am responsible for all reasonable charges incurred if this amount is turned over to an attorney for collection.

NOTICE OF INFORMATION PRIVACY PRACTICES

I acknowledge that I have been shown the posted Notice of Information Practices by AccelAbility Balance & Therapy.
I certify that I understand these rights as set forth.

Signature of Patient: Date:

Information below is required for treatment of a minor or a patient who does not have their own power of attorney.
Name of Parent or Legal Guardian: Signature: