Vail Physical Therapy

Patient Intake

Name:_____ DOB:_____ Date:_____
SSN:_____ Cell #: _____ Home #: _____
Mailing Address:_____
City: _____ State: _____ Zip: _____
Email address:_____
Name of Referring Physician/Friend/Relative: _____
Exact Date of Accident/Onset of Symptoms: _____
Gender: M F Marital Status: Married Single Divorced Widowed Other
Emergency Contact Name: _____ Phone:_____

If work comp, employer name/phone #:_____
_____

Insurance Plan (circle one) Work Comp Auto Medicare Private Insurance Self Pay
(Work Comp, Auto and Medicare must have a valid/current prescription for physical therapy)

Insurance Company: _____
Address for Claims: _____
Group #/Claim #: _____
Name of Policy Holder: _____
Relationship to Policyholder:_____ Policyholder DOB: _____

Financial Policy
We emphasize that, as healthcare providers, our relationship is with your, not your insurance company. We will bill your insurance company providing you give us an accurate, legible copy of your current insurance card (both sides) at your first appointment. We do not take any responsibility for any denial of claims by your insurance company (including but not limited to): denials due to lack of authorization, pre-authorization, limitations on your insurance policy, or because of any delays in receiving your health insurance information. Verification of your insurance benefits does not guarantee payment by your insurance company. You are responsible for understanding any/all limitations on your insurance policy, including visit limits/caps on amount paid, etc.

Guarantee of Payment
I hereby guarantee payment of physical therapy expenses for the above-mentioned patient while at Vail Physical Therapy, LLC. I am the patient/legal guardian/parent etc. for the above patient and accept legal responsibility for all expenses. I understand that I am financially responsible to Vail Physical Therapy, LLC for any/all expenses incurred, including those not covered by or paid for by my insurance company. I also understand that I am financially responsible if a problem develops with my insurance carrier and payment is not made within 60 days.
Should this account become delinquent, I understand that I will be responsible for any and all collection/attorney/filing fees incurred in trying to collect payment.
I verify that the above information is current and accurate. I have read and agree to the statement above and I am seeking treatment voluntarily. My signature authorizes payment of any insurance benefits to the supplier of services (I assign any/all benefits directly to Vail Physical Therapy, LLC.).

Cancellation Policy
Vail Physical Therapy reserves the right to charge $25.00 for appointments not canceled with at least 24 hours notice for first offense, and $50.00 for each additional offense.

Signed_____ Date_____

Vail Physical Therapy, LLC

Medical History

(Please circle if you have had medical history)

Patient Name: _____ DOB: _____

Allergies
Anemia
Anxiety
Arthritis
Asthma
Autoimmune Disorder
Cancer
Cardiac Conditions
Cardiac Pacemaker
Chemical Dependency
Circulation Problems
Current Pregnancy
Depression
Diabetes
Dizzy Spells
Emphysema/Bronchitis
Fibromyalgia
Fractures
Gallbladder Problems
Headaches
Hearing Impairment
Hepatitis
High Cholesterol
High/Low Blood Pressure
HIV/AIDS
Incontinence
Kidney Problems
Metal Implants
MRSA
Multiple Sclerosis
Muscular Disease
Osteoporosis
Parkinson's
Rheumatoid Arthritis
Seizures
Smoking
Speech Problems
Stroke
Thyroid Disease
Tuberculosis
Vision Problems

List any surgeries and the date(s) you had them:

List any medications you take below:

Signature: _____ Date:_____