Scanlon Physical Therapy, Inc.

Date: _____
Time: _____

New Patient Intake Form

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Insurance Company: _____ Self Insured: Yes or No

Subscriber Name: _____ DOB: _____ Relation: _____

Injury Related Questions:

What is your injury: _____ Date of Injury: _____

Is your injury car accident related? _____

Is your injury worker's compensation related? _____

If your injury is Workers Compensation or Accident Related, Please complete this section:

Circle One: Accident Related / Workers Compensation Date of Injury: _____

Insurance Company: _____ Claim #: _____

Insurance Billing Address: _____

Adjuster Name: _____ Phone #: _____ ext. _____

Attorney Name: _____ Phone #: _____

Please read the below statements, check the boxes and sign.

☐ **Assignment** & **Release:** I authorize my insurance benefits to be paid directly to the provider and acknowledge that I am financially responsible for any unpaid balance. I authorize the release of any information by the above insurance company.

Co-payments, Deductibles, Co-Insurance and Self pay: According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurance. If you have questions about your insurance benefits for physical therapy, contact your insurance company or ask the office staff.

☐ I understand and agree to pay all co-payments, deductible amounts and co-insurance amounts owed to Scanlon Physical Therapy Inc.

☐ I have read and understand my rights as a patient

Signature of Patient or Guardian: _____ **Date:** _____