

OFFICE USE ONLY

MD RX

INS CO AUTH

ICD9 CODE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MOVEMENT IMPAIRED DIAGNOSIS

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**NEW PATIENT INTAKE FORM**

NAME *(first)* \_\_\_\_\_ *(middle)* \_\_\_\_\_ *(last)* \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE *(home)* \_\_\_\_\_ *(work)* \_\_\_\_\_ *(cell)* \_\_\_\_\_

EMAIL \_\_\_\_\_ @ \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

REFERRING MD \_\_\_\_\_ PRIMARY MD \_\_\_\_\_

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR FOR THIS CONDITION? Yes No

DATE INJURY/CONDITION OCCURED \_\_\_\_\_ DATE OF SURGERY \_\_\_\_\_

WHAT MOST INFLUENCED YOU TO CHOOSE OUR FACILITY? (PLEASE CHECK ONE)

\_\_\_\_ DOCTOR REFERRAL      \_\_\_\_ LOCATION      \_\_\_\_ FORMER PATIENT

\_\_\_\_ INSURANCE      \_\_\_\_ FRIEND      \_\_\_\_ OTHER (please specify)

\_\_\_\_\_

**PLEASE READ AND SIGN**

Most health insurance policies provide coverage for physical therapy. However, contracts vary concerning percentage of payment and we suggest you check with your insurance company for this information. Filing of insurance claims is a service provided to our patients and in no way relieves you of the responsibility for your bill. Co-payment/ coinsurance is expected at the time of service. We accept VISA, MasterCard, Discover Card, and American Express for your convenience.

I authorize workers' compensation, no-fault, or my insurance company to pay Moriarty Physical Therapy, P.C. directly for medical benefits. I also authorize the release of any medical or other information necessary to process my claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_

PRIMARY INSURANCE COVERAGE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP \_\_\_\_\_ CO-PAYS \_\_\_\_\_

DEDUCTIBLE \_\_\_\_\_ MET? YES NO

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SUBSCRIBER NAME \_\_\_\_\_ TELEPHONE# \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT'S ADDRESS) \_\_\_\_\_

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WC/NF INS CO NAME \_\_\_\_\_

TEL. # \_\_\_\_\_ ADJUSTER/CASE MANAGER \_\_\_\_\_

WCB/ POLICY # \_\_\_\_\_ CC #/ CLAIM \_\_\_\_\_

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SECONDARY INSURANCE COVERAGE \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DOB \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

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**PLEASE READ AND SIGN**

Physical Therapy treatment usually takes between 45 -90 minutes depending on the procedures used. An appointment is necessary for each treatment. We ask that you call the office one day prior by 7:00 PM if you cannot keep the appointment, or there may be a \$25.00 fee charged to you. Your insurance company will not be billed for missed appointments. The answering machine is available on weekends and holidays only.

I understand and agree to this appointment policy.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

As a courtesy to other patients as well as the therapists, we ask that you make every effort to adhere to your scheduled time. Thank you.

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