PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name: ___________________________ Male/Female DOB_______________

Status: Single/Married/Widowed/Other (CIRCLE ONE)

SSN:________________________

Driver's License No:________________________________

Physical Address: ____

Mailing Address: ____

Phone Number
Home: (   )___________________________ Cell: (   )_____________________________

Email: ____
Occupation: ______________________________ Status: Full Time/Part time/Modified Activity
Employer: ______________________________
Employer Address: ____
Emergency Contact Person: _________________________ Relationship to Patient: __________
Contact Number: ____________________________

Financial Responsibility (If patient is minor): ____
Relationship to patient: ___________________________ DOB_____________________________
Address: ____

Phone Number: Home _________________________ Cell _____________________________

Crux Rehabilitation
5665 Power Inn Road #121 Sacramento CA 95824
1050 Opportunity Dr #120 Roseville CA 95678
Phone: 916-669-9038 Fax: 916-529-4161

Patient Name: ______________________________________ **DOB**_________________

PROVIDER & INSURANCE INFOPRMATION
Primary Care Provider __________________________ Phone ( )____________________

Address ____

Referring Provider ______________________________ Phone ( )____________________
Address ____

Primary Insurance: ____
ID Card #______________________________ Group # _________________________________
Effective Date _________________________ Subscriber Name _________________________
DOB _________________ Relationship to the Patient _______________________Male/Female

Secondary Insurance (If applicable): ____
ID Card #______________________________ Group # _________________________________
Effective Date _______________________ Subscriber Name ___________________________
DOB _________________Relationship to the patient_______________________ Male/Female

Workers Comp (If applicable) ____
Adjuster __________________________ Contact Information: __________________________
Employer at Time of Injury_______________________ Date of Injury _____________________
Authorization # ____________________________

Attorney's Name (If applicable) ________________________________ Contact Number ( )
____
Address____

Auto Insurance (If applicable) __________________________ Date of Injury_______________
Insured's Name _______________________________ DOB _____________________________
Relationship to the patient ______________________________ Male/Female ______________
Claim Number ________________________ID Card or Policy # __________________________

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CONSENT FOR TREATMENT: I hereby certify by signing below, that I give Crux Rehabilitation permission to perform physical therapy services on myself or my child (if applicable, even in absence of the parent or legal guardian) as appropriately determined by treating physical therapist and staff. I authorize Crux Rehabilitation to communicate with the Referring Physician/referring office and Emergency contact person above during the course of my or my child's treatment.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Crux Rehabilitation to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Crux Rehabilitation. I authorize Crux Rehabilitation to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand I am responsible for knowing and meeting the requirements of my insurance plan. I hereby certify by signing below (whether as agent or patient) that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services. I hereby authorize and assign the Crux Rehabilitation any and all benefits arising out of any type of insurance or payer, which insures the patient bill.

AUTHORIZATION FOR EMAIL APPOINTMENT REMINDERS:

I, __________________________ authorize Crux Rehabilitation to send me appointment reminders through email/text as provided on intake form.
I, __________________________ authorize Crux Rehabilitation staff to communicate through email, mail, answering machine and/or text

WRITTEN ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, ____ hereby acknowledge that I have received a copy of The Notice of Privacy Practices.
Signature: ____ Relationship to Patient (if patient is a minor): _________________________
Date: _________________________

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Patient Name: ___________________________________ DOB________________

Release of Medical Information

I, _________________________________ authorize Crux Rehabilitation staff to communicate/discuss or release all medical information (information about appointments, medical records, history, current treatment, diagnosis, prognosis and medical bills) to the people listed below. This authorization compiles with the Confidentiality of Medical Information Act, Section 56.

1) Name ___________________________________ Relationship_________________
Contact Number(optional)_____________________________________Male/Female
2) Name ___________________________________ Relationship_________________
Contact Number(optional)_____________________________________Male/Female
3) Name ___________________________________ Relationship_________________
Contact Number(optional)_____________________________________Male/Female
4) Name ___________________________________ Relationship_________________
Contact Number(optional)_____________________________________Male/Female

Signature of Patient _______________________________ Date _________________
Guardian Signature (if applicable) _________________________

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