Patient Intake Form Today's Date: _____

Patient Name: _____ D.O.B. _____ Gender :_____

Status: Single / Married / Widowed / Other (Circle One)

SSN: _____

Mailing Address/ P.O. BOX _____

City, State_____Zip Code_____

Phone Number: _____ Home Number: _____

Email: _____

Work Status: Full Time / Part Time / Modified

Employer: _____ Employer Phone Number: _____

Occupation: _____

Employer Address: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____

Financial Responsibility (If patient is a minor): _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

Patient Intake Form

Consent for Treatment: I hereby certify by signing below, give permission to Crux Rehabilitation to Perform physical therapy services on myself or on my child (if applicable, even in the absence of the parent or legal guardian) as appropriately determined by the physical therapist and staff. I authorize Crux Rehabilitation to communicate with the referring Physician/Referring Office and Emergency Contact person above during 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 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 agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand it is my responsibility to inform Crux Rehab if there are any changes in Insurance information and if or incorrect insurance information was provided during intake. I understand it is my responsibility to confirm if Physical Therapy services are covered by Crux with my insurance. I understand I am responsible for knowing and meeting the requirements of my insurance plan. In case of denials, I will be responsible for reimbursing Crux Rehab for the services provided. 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 all benefits arising out of any type of insurance or payer, which insures the patient bill.

Signature: _____ Date: _____

Authorization for Appointment Reminder:

I, _____ authorize Crux Rehabilitation to send me appointment reminders through text/email/answering machine as provide in my intake form.

I, _____ authorize Crux Rehabilitation staff to communicate through email, mail, answering machine and/or text.

Signature: _____ Date: _____

Patient Intake Form

Cancellation/ No Show Policy for Physical Therapy Appointment at Crux Rehabilitation.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not canceled at least **24 hours** in advance the appointments missed will be noted down as a **NO-SHOW AND THERE WILL BE A $50 FEE CHARGED PER MISSED APPOINTMENT.** Please acknowledge that a record of a **NO-SHOW** can potentially affect your case negatively. Please contact your adjuster or attorney for further questions.

I acknowledge that not cancelling an appointment at least 24 hours in advance will result in a **NO-SHOW** and a **$50 FEE** to my record while attending at Crux Rehabilitation.

_____ Please Initial

If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

_____ Please Initial

I acknowledge that after two **NO-SHOWS**, I will be released from Physical Therapy at Crux Rehabilitation.

_____ Please Initial

Print Name: _____ Date: _____

Signature: _____ Date: _____