Physical Therapy
Doyle & Taylor

NEW PATIENT INTAKE FORM

DATE: _____

Last Name:		First Name:
Date of Birth:		SSN:
Address:		Apt. or P.O. Box:
City:	State:	Zip:
Phone Numbers:		Gender: Male ☐ Female ☐
Home:		Email:
Work:		Date of Injury:
Cell:		Date of Surgery:

EMERGENCY CONTACT

Last Name:	First Name:
Phone:	Relationship to patient:

EMPLOYER INFORMATION

Name of Employer:		
Address:		Apt. or P.O. Box:
City:	State:	Zip:

REASON FOR TREATMENT:

Description of Problem:	
Physician/PA/NP Referred by:	Date of Order (if ins req):

PRIMARY INSURANCE

Subscriber's Name:		Subscriber Relationship to Patient:
Subscriber's Birthdate:		☐Self ☐ Spouse ☐ Parent ☐ Other
Insurance Company:		Policy Number:
Group Number:		Claim Number:
Address:		P.O. Box:
City:	State:	Zip:

SECONDARY INSURANCE

Subscriber's Name:		Subscriber Relationship to Patient:
Subscriber's Birthdate:		☐Self ☐ Spouse ☐ Parent ☐ Other
Insurance Company:		Policy Number:
Group Number:		Claim Number:
Address:		P.O. Box:
City:	State:	Zip:
If Workers Compensation or Auto Accident:		
Claim Adjustor Name:		Claim Adjustor Phone:
Claim #:		Date of Accident:

RESPONSIBLE PARTY STATEMENT: AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY SIGNATURE X	TODAY'S DATE:

Initials: _____ Initials: _____	Late Cancellation and No-Show FEE is $40.00. We require a 24 HR notice to cancel an appointment unless there is an unforeseen/emergency circumstance. Grace period: If you are 10 or more minutes late for any appointment, you will be required to reschedule the appointment and pay the late cancellation fee of $40.00.
Initials: _____	Notifications and Reminders: Please send any notifications and/or appointment reminders as: f ☐ Text message to my cell phone only ☐ Email me only ☐ Text message to my cell phone and email me ☐ I do not want any reminders or notifications
Initials: _____	I have read and fully understand Doyle & Taylor Physical Therapy's Notice of Information Practices. I understand that Doyle & Taylor Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health insurance is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Doyle & Taylor Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Doyle and Taylor Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.
☐ YES ☐ NO	Have you had PT/OT this year? If YES, when/where:

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO DOYLE& TAYLOR PHYSICAL THERAPY, LLC IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THIS PRINCIPAL AMOUNT AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLLY) FOR UNPAID BALANCES OVER THIRTY (30) DAYS OLD. IF REIMBURSEMENT IS MADE BY OTHER PAYER SOURCES, I.E. ATTORNEYS, ATTORNEY LIENS, OR THIRD-PARTY INSURANCES, NEGOTIATED INSURANCE DISCOUNTS WILL NOT APPLY. PAYMENT IN FULL PER THE CLINIC'S FEE SCHEDULE IS EXPECTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMNET OF THE SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF DOYLE & TAYLOR PHYSICAL THERAPY, LLC AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY, OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE:	TODAY'S DATE: