

Welcome

Thank you for selecting our healthcare team! Altitude Physical Therapy & Sports Medicine is committed to excellence in serving the health needs of the community. We are dedicated to giving each Patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you.

For office
use only

Acct _____

RX
Code _____

PT/Provider

INTAKE
COMPLETE
D BY

DATE:

Patient Information

Name Last _____ First _____ MI _____ Date _____
Current address _____
City _____ State _____ Zip _____
LOCAL Phone H _____ W _____ Social Security _____
 Male Female Student Single Married Divorced Widowed Separated
Date of Birth: month _____ day _____ year _____ Drivers License _____
Permanent Address _____ Phone _____
City _____ State _____ Zip _____
Employer _____ Occupation _____
Employer address _____
City _____ State _____ Zip _____

General information

Referring Doctor _____ Family Doctor _____
Description of Problem _____ Date of Onset _____
Was there an Accident? Auto _____ Work _____ Other _____ Claim Number _____
Adjuster _____ Adjusters Phone Number _____
Have you had Surgery? Y _____ N _____ If yes when? _____ Surgeon _____

Responsible party

Who is responsible for the account?
Name Last _____ First _____ MI _____ Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Social Security Number _____ Insurance ID number _____
 Male Female Single Married Divorced Widowed Separated
Date of Birth: month _____ day _____ year _____ Drivers License _____
Employer _____ Occupation _____
Home phone _____ Work Phone _____
Insurance Company _____ Insurance Phone _____
Plan Number _____ Is There Secondary Insurance? Y _____ N _____

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

Assignment of Benefits: I hereby assign payment directly to Altitude Physical Therapy & Sports Medicine who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature _____ Date _____

Unaccompanied Minors

The parents (or guardians) are responsible for full payment at the initial visit. Subsequent charges may be billed to the insurance but co-payments, deductibles, and non-covered amounts must accompany the minor at each visit.

Initial box

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.