ALTITUDE PHYSICAL THERAPY INTAKE FORM

PATIENT INFO: Date:___________________

Name:____ Sex: M or F

Address:____

City:__________________________ State:___________ Zip: ________________________

Home Phone:___________________ Cell:___________________ Work:____________________

Date of Birth:_________________________ SSN:_______________________________________

Emergency Contact:______________________________ Phone:__________________________

Email address:____(optional)

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Preferred method of contact: -Phone - Email -Text

How did you hear about us? - Doctor _________________ - Location

- Advertisement -Friend ________________________ -Other:________________

EMPLOYMENT INFO:

Employer:_______________________________________Phone:__________________________

Policy Holder's SSN:______________________________Date of Birth:____________________

CONDITION INFO:

Referring MD: ____________________Date of last MD visit:_________________________

Date of Onset:________________Injury: Y / N Auto W/C Other:______________________

INSURANCE ASSIGNMENT AND PATIENT FINANCIAL RESPONSIBILTY:

*As a courtesy to our patients, Altitude Physical Therapy will verify your insurance benefits and bill your insurance company directly. However, as the patient/guarantor, you are ultimately responsible for any co-pays or balance on your account. If services are not covered, benefits exhausted, or insurance denies your claims, you will be billed directly for all services rendered.

* We require **24 hours notice** to cancel an appointment. Should you cancel your appointment with less than 24 hour notice, OR no show to your scheduled appointment you will be billed a **$25 missed appointment fee** which will be DUE AT THE TIME OF YOUR NEXT APPOINTMENT. If you have any questions please ask.

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Patient/Guarantor Signature Date

ALTITUDE PHYSICAL THERAPY, INC.
INFORMED CONSENT

Authorization for Medical Treatment: I authorize the physical therapist(s) responsible for the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited, routine diagnostic procedures, the use of physical modalities, and the prescription of therapeutic exercise. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician or physical therapist whose care the patient is under.
I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to results of examination and treatment in Altitude Physical Therapy, Inc. I acknowledge that my care is under the direction of my treating physician(s) in the provision of said care.
Assignment of Facility Benefits: I/we assign all benefits to Altitude Physical Therapy, Inc. and authorize direct payment to Altitude Physical Therapy, Inc., 211 E. Logan, Suite 101, Caldwell, Idaho 83605, all insurance benefits or Medicare/Medicaid benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.
Statement of Responsibility: I understand that I am financially responsible to Altitude Physical Therapy, Inc. as the patient, parent, guardian, conservator, or insured for all charges not covered by the above assignment. These charges may include any medical insurance deductibles, co-pays, and/or co-insurance. I understand that to sign as a Guarantor means that if the patient does not pay Altitude Physical Therapy, Inc. for all services due, I, as Guarantor, will be responsible for such payment. I further understand that payment is due 30 days after receiving the billing statement; if there has been no payment toward my account in excess of 60 days, there may be levied interest and/or late fees at the current rate allowed by law. Any accounts turned over to a Collection Company will incur a **30% c**ollection fee calculated by the balance of the account.
Authorization to Release Information to Insurance Company/Third Party Payer: I authorize Altitude Physical Therapy, Inc. and any physical therapist, practitioner, or other person, any hospital including Veteran's Administration or governmental hospital any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.
HIPPA Acknowledgement: I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPPA.
Authorization for Quality Review: I acknowledge that it may be appropriate for Altitude Physical Therapy, Inc. to review the overall care provided to the patient following the cessation of treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of care provided to Altitude Physical Therapy, Inc. patients. Therefore, I authorize the physical therapists and/or representatives of Altitude Physical Therapy, Inc. through their Process Improvement Initiative to review copies of records regarding my care in order to establish clinical pathways and improved standards of care.
Personal Valuables: Altitude Physical Therapy, Inc. shall not be liable for the loss of or damage to any personal property.

The undersigned certifies that he/she has read the foregoing or is the parent or duty authorized by or on behalf of the patient to execute the above and accept its terms.

Patient's Signature/Parent if Minor/Power of Attorney	Date
Responsible Party's Signature (if not same as patient or parent)	Insured's Signature
Witness to Signatures	Patient Unable to Sign Consent Because: