Institute of Physical Therapy and Fitness

678 Southway Ave
Lewiston, ID 83501
Phone (208) 746 1418
Fax (208) 746 4123

PATIENT INTAKE FORM

Personal Information	Please Print Legibly
Name (Last, First, MI):	Gender: Male Female
Date of Birth:	Social Security Number:
Home Address/ Mailing Address:	
City, State, Zip Code:	
Phone #:	Cell Phone #:
Email Address:	
Marital Status:	M S D W
Emergency Contact:	Name: Phone#:
Relationship to Emergency Contact:	
Date of Surgery or Fall:	
Referring Physician:	
Next Doctors Appointment:	
Home Health Care:	Are You Currently Being Treated at Home: YES or NO
Why Did You Choose this PT?:	
Primary Insurance	Insurance Provider:
Policy Holder Name:	
Policy Holder Date of Birth:	Policy Holders SSN:
Policy Number:	
Secondary | Supplementary	Insurance Provider:
Policy Holder Name:	
Policy Holder Date of Birth:	Policy Holders SSN:
Policy Number:	
Relationship to Policy Holder:	Self Spouse Parent Other

Release of Information: Institute of Physical Therapy and Fitness may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Institute of Physical Therapy and Fitness may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Institute of Physical Therapy and Fitness may release all or any part of my record to any federal, state, or local government body when, in the opinion of Institute of Physical Therapy and Fitness such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

Financial Consent: I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Institute of Physical Therapy and Fitness will bill me, my family, and/or other responsible parties for services provided.

Assignment of Insurance Billing: I and/or the responsible party voluntarily assign Institute of Physical Therapy and Fitness and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

No-Show/ Cancellation Policy: All patients who do not cancel their appointment within **24-hours** or more of their scheduled appointment will be charged **$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment within that week. Patients who do not show up to their appointment and do not call to cancel will receive a **$25.00** "No-Show" fee.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Institute of Physical Therapy and Fitness's Notice of Privacy Practices on this day and have read the terms above and agree to them.

Signature:_____ **Date:**_____