Patient Intake Form

Name_____SS#_____
Last First MI

Address_____

City_____State____Zip_____Email Address_____

Home Phone_____ Cell Phone_____Cell Service Provider_____

☐Male ☐Female Age_____ Date of Birth_____ Marital Status_____

Emergency Contact_____Phone_____

Current work status: ☐Full-Time ☐Part-Time ☐Retired ☐Disabled ☐Homemaker ☐Do not work

Occupation:_____

Primary Care Physician_____Referring Physician_____

****If this is a school related injury, please inform the front desk to expedite claim submission**

Primary Insurance Carrier

Insurance Name _____ Relationship to Insured_____

Policy Holder Name_____ Policy Holder Date of Birth_____

Secondary Insurance Carrier

Insurance Name _____ Relationship to Insured_____

Policy Holder Name_____ Policy Holder Date of Birth_____

For Worker's Compensation

Date of Injury/Accident: _____Claim #_____

Case Manager (if applicable)_____Phone_____

Employer_____ Occupation_____

Employer Address _____

For Motor Vehicle

Accident Date: _____State Where Accident Occurred_____ Claim #_____

Adjuster Name_____Phone_____

Insurance Company Name _____

Attorney's Name (if applicable)_____ Phone_____

Consent For Treatment, Insurance / Reimbursement and Privacy Rights

Name _____(Please Print) DOB_____

I hereby authorize *ProCare Rehabilitation LLC* through its duly authorized agents, to perform or have performed upon me, or the above named patient, such assessment and treatment procedures as are deemed necessary and/or appropriate.

Patient/Parent/Guardian _____Date _____

I understand and agree that (regardless of my insurance status): I am financially responsible for my account for any professional services rendered that are not otherwise paid or reimbursed. I hereby authorize my insurance company assign my benefits directly to ProCare Rehabilitation LLC benefits payable to me. I also agree to be responsible for payment of all services rendered on my behalf for my dependents. I understand and agree that should my account be turned over to a collection agency, I may be responsible for up to an additional 32% of the unpaid balance.

Patient/Parent/Guardian _____Date _____

PRIVACY NOTICE: I have been offered a copy of the NOTICE of PRIVACY PRACTICES and have _____accepted /_____declined a copy.

In addition to the Notice of Privacy Practices, I hereby allow *ProCare Rehabilitation* to disclose information regarding my care to the following individuals:

Name *Relationship*

1._____

2._____

3._____

Patient/Parent/Guardian _____Date_____

Name:_____ **Date:** _____

Height:_____ **Weight:**_____

Medical History

Please add any additional current or past medical history that you need to inform our staff of prior to your evaluation (e.g., Osteoporosis, Hypoglycemia, Recent bone injuries, Pregnancy, Dizziness, etc.):

_____

_____

_____

_____

Surgeries/Hospitalizations:

	Surgery Type	**Hospital**	**Dates**
1.			
2.			
3.			
4.			

Please specify any allergies: _____

_____

Current prescription and/or over the counter medications:

_____

_____

The ProCare Promise

ProCare Rehabilitation offers FULL billing transparency based on the information your insurance company provides us. We PROMISE to disclose your out-of-pocket payment responsibility within the first week of your initial evaluation.

- Every patient will be given a detailed insurance benefit sheet with the information that was provided to us by your insurance company.
- ProCare asks you to please call your insurance company to double check the information

With that, ProCare requires all patients to extend the courtesy of putting their credit card on file to simplify the patient experience and to maintain your account in good standing.

Please provide the following information:

__Amex __Visa __Mastercard __Discover

Credit Card Number _____

Expiration Date _____/_____/_____ CCV (Security Code): _____

Cardholder Name _____

Patient Name_____

Billing Address _____

City _____ State _____ Zip _____

I, the undersigned, authorize and request ProCare Rehabilitation to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by ProCare Rehabilitation, LLC

Signature: _____

Email Address(for receipt):_____

Date:_____