Function Rehabilitation
Patient Intake Form

Basic Information

Patient Name: (First)_____(Last) _____
Date of Birth: _____ Sex: M F
Phone: _____
Address: _____ City: _____State: _____
_____Zip: _____

Emergency Contact

Name: _____ Phone: _____
Relationship: _____

Medical History

Who referred you to us?: _____
Phone: _____
Case Manager: _____ Phone: _____
Reason for therapy: _____
_____
Date of Accident (If applicable): _____

Allergies?: Y N If so, what?: _____
_____
_____

Current Medications: _____
_____
_____

Insurance Information

Name of Insurance: _____
Billing Address: _____ City: _____State: _____
_____ Zip: _____
Auto Adjustor: _____ Phone: _____

If Work Related

Worker's Compensation: Y N

If yes:

Name of Adjustor: _____ Phone: _____

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip: _____

Final Policy

Thank you for seeing Function Rehabilitation for your therapeutic needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised the payment for all services will be due at the time services are rendered, unless prior arrangements have been made or you have provided us with the insurance you would like us to bill for you.

( ) I agree to this statement and should this account be referred to any agency or an attorney for collection, I will be responsible for all collection costs, including attorney fees and court costs.

( ) The information that I have provided is complete and accurate to the best of my knowledge. I understand treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any arising consequences.

_____

Patient's Signature Date