PATIENT INTAKE FORM

South Sound Physical & Hand Therapy

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Preferred Name _____ Preferred Pronoun _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Cell Phone (___) _____ - _____ Alternate Phone (___) _____ - _____ DOB ___/___/___ Gender ☐F ☐M

Permission to Text Appointment Reminders ☐Y ☐N Social Security # _____ - ___ - _____

☐ I hereby give permission for IRG &/or Affiliates to leave detailed messages on my voicemail/answering machine.

Email Address _____

☐ I hereby give permission to IRG, Inc. & Affiliates to send me an email.

How did you hear about us? ☐Health Care Provider ☐Friend/Relative ☐Website ☐Other

Parent Name _____ Address _____
(If patient is a minor) *(If different from above)*

Cell Phone (___) _____ - _____ Alternate Phone (___) _____ - _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone (___) _____ - _____

PROBLEM

Injury/ Body Part(s) _____ Date of Surgery ___/___/___ Last MD Visit ___/___/___

Referring Provider _____ Primary Care Physician _____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

CLAIM INFORMATION *(IF APPLICABLE)*

☐L&I Claim ☐Worker's Comp/Self-Ins Claim Date of Injury ___/___/___ Employer _____

Claim Manager's Name _____ Phone (___) _____ - _____ Ext. _____

☐Motor Vehicle Accident Date of Accident ___/___/___ State Accident Occurred _____

Your Car Insurance Company _____ Available P.I.P? ☐Y ☐N

Adjuster's Name _____ Phone (___) _____ - _____ Ext. _____

IRG & AFFILIATES HIPAA PRIVACY - *CHECK ALL THAT APPLY*

☐I acknowledge receipt of a copy of the Notice of Privacy Practices

☐I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

☐I hereby give permission for IRG & Affiliates to discuss my medical information with _____

Consent for treatment, Assignment of Benefits, & Release of Information: I hereby authorize you to evaluate & treat me (or my dependent) and I assign directly to Integrated Rehabilitation Group, Inc. & LLC Affiliates all medical insurance benefits, if any for services rendered.

I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature _____ Date _____
(Parent or Guardian if patient is a minor)