PEAK Physical Therapy

550 Chase Avenue
Waterbury, CT 06704
T: 203-757-0100
F: 203-757-0102

# Patient Intake Form

NAME: (First, Middle, Last) _____

SSN _____ Marital Status: S M D W

Date of Birth_____/_____/_____ Male ☐ Female ☐

Address: _____

City: _____ State: _____ Zip: _____

Primary Tel.: _____ HOME ☐ CELL ☐

Secondary Tel.: _____ HOME ☐ CELL ☐

Email: _____

*Would you like to receive our monthly newsletter via email?*
YES ☐ NO ☐

Emergency Contact: _____

Emergency Contact Tel: _____

How did you hear about us? _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORKMAN'S COMP. CLAIM? YES ☐ NO ☐

Date of Injury: _____ State Injury Occurred: _____

Insurance Carrier: _____

WC Claim #: _____

Employer/Comp Contact Person: _____

Employer/Comp Contact Phone #: _____

Referring Doctor: _____

City: _____

Primary Care Physician: _____

City:_____

**Can we inform your PCP of your treatment? YES ☐ NO ☐**

**If yes, please provide PCP phone#:_____**

IS THIS RESULT OF A SLIP & FALL OR MVA? YES ☐ NO ☐

Date of Injury: _____ State Injury Occurred: _____

Are you working with an Attorney? YES ☐ NO ☐

Attorney: _____

Phone #_____

City: _____ State: _____ Zip: _____

## INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____

Secondary Insurance: _____

ID Number: _____

Tertiary Insurance: _____

ID Number: _____

## TERMS OF SERVICE

**1.** Co-pay and/or other payment due at time of service. This office accepts cash, checks, and credit cards.

**2.** There will be a $25.00 charge for returned checks.

**3.** If account remains unpaid and it is necessary for Peak Physical Therapy to engage in collection action, all costs will be charged to you (court, attorney, interest, and collection agency fees).

**4.** Appointments must be canceled at least 24 hours in advance, otherwise $25 will be charged to the account.

**5**. Charges not authorized by insurance are charged to account**.**

***Please remember that while we will verify your benefits and obtain authorization if applicable to your plan, it is your responsibility to know your benefits and deductibles etc. We also remind you to notify our office immediately upon any insurance changes as this may change your responsibility. ***

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**Signature of patient or guardian:** _____ **Date:** _____

PEAK Physical Therapy

550 Chase Avenue
Waterbury, CT 06704
T: 203-757-0100
F: 203-757-0102

# Patient Intake Form

NAME: (First, Middle, Last) _____

SSN _____ Marital Status: S M D W

Date of Birth_____/_____/_____ Male ☐ Female ☐

Address: _____

City: _____ State: _____ Zip: _____

Primary Tel.: _____ HOME ☐ CELL ☐

Secondary Tel.: _____ HOME ☐ CELL ☐

Email: _____

*Would you like to receive our monthly newsletter via email?*
YES ☐ NO ☐

Emergency Contact: _____

Emergency Contact Tel: _____

How did you hear about us? _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORKMAN'S COMP. CLAIM? YES ☐ NO ☐

Date of Injury: _____ State Injury Occurred: _____

Insurance Carrier: _____

WC Claim #: _____

Employer/Comp Contact Person: _____

Employer/Comp Contact Phone #: _____

Referring Doctor: _____

City: _____

Primary Care Physician: _____

City:_____

**Can we inform your PCP of your treatment? YES ☐ NO ☐**

**If yes, please provide PCP phone#:_____**

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Date of Injury: _____ State Injury Occurred: _____

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Attorney: _____

Phone #_____

City: _____ State: _____ Zip: _____

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Address: _____

City: _____ State: _____ Zip: _____

Primary Tel.: _____ HOME ☐ CELL ☐

Secondary Tel.: _____ HOME ☐ CELL ☐

Email: _____

*Would you like to receive our monthly newsletter via email?*
YES ☐ NO ☐

Emergency Contact: _____

Emergency Contact Tel: _____

How did you hear about us? _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORKMAN'S COMP. CLAIM? YES ☐ NO ☐

Date of Injury: _____ State Injury Occurred: _____

Insurance Carrier: _____

WC Claim #: _____

Employer/Comp Contact Person: _____

Employer/Comp Contact Phone #: _____

Referring Doctor: _____

City: _____

Primary Care Physician: _____

City:_____

**Can we inform your PCP of your treatment? YES ☐ NO ☐**

**If yes, please provide PCP phone#:_____**

IS THIS RESULT OF A SLIP & FALL OR MVA? YES ☐ NO ☐

Date of Injury: _____ State Injury Occurred: _____

Are you working with an Attorney? YES ☐ NO ☐

Attorney: _____

Phone #_____

City: _____ State: _____ Zip: _____

## INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____

Secondary Insurance: _____

ID Number: _____

Tertiary Insurance: _____

ID Number: _____

## TERMS OF SERVICE

**1.** Co-pay and/or other payment due at time of service. This office accepts cash, checks, and credit cards.

**2.** There will be a $25.00 charge for returned checks.

**3.** If account remains unpaid and it is necessary for Peak Physical Therapy to engage in collection action, all costs will be charged to you (court, attorney, interest, and collection agency fees).

**4.** Appointments must be canceled at least 24 hours in advance, otherwise $25 will be charged to the account.

**5**. Charges not authorized by insurance are charged to account**.**

***Please remember that while we will verify your benefits and obtain authorization if applicable to your plan, it is your responsibility to know your benefits and deductibles etc. We also remind you to notify our office immediately upon any insurance changes as this may change your responsibility. ***

**ASSIGNMENT AND RELEASE:** I, the undersigned, assign directly to Peak Physical Therapy, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid for by insurance. I hereby authorize Peak Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions. I understand that I am responsible to know my insurance benefits and that all charges not covered by my insurance will be billed directly to me. Should my injury be related to a workplace or motor vehicle accident I will accept responsibility for payment of physical therapy evaluation and treatment costs should the claim be denied by the third-party payer. I have read and understand the Terms of Service above.

**Signature of patient or guardian:** _____ **Date:** _____