

# NORTH VALLEY PT & OT : PATIENT INTAKE AND CONSENT FORM

|                           |  |   |   |
|---------------------------|--|---|---|
| <b>Internal Use Only:</b> | Account # <input style="width: 90%;" type="text"/> | Account Type <input style="width: 90%;" type="text"/> | Office # <input style="width: 90%;" type="text"/> |
|---------------------------|--|---|---|

|  |  |
|--|--|
| First Name _____ MI _____<br>Last Name _____<br>Address _____<br>City _____ State ____ Zip _____ | Date of Injury/Onset _____ Today's Date _____<br>Date of Birth _____ Age _____<br>Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W<br>Home Phone _____<br>Work Phone _____ |
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|--|
| Responsible Party _____<br>Address _____<br>City _____ State ____ Zip _____<br>Phone Number _____<br>Relationship to Responsible Party _____ |
|--|

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|---|
| Cell Phone _____<br>Injury Area _____<br>Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other<br>Nature of Accident _____<br>SS# _____ |
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|--|
| Employer _____<br>Address _____<br>City _____ State ____ Zip _____ |
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|   |
|---|
| Occupation _____<br>Contact at Employer _____ |
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|                           |                    |
|---------------------------|--------------------|
| Referring Physician _____ | Phone Number _____ |
|---------------------------|--------------------|

|  |   |
|--|---|
| Primary Insurance _____<br>Group # _____ ID # _____<br>Insured Employer _____<br>Relationship to Insured _____ | Insured Name _____<br>Address _____ City _____<br>State _____ Zip _____ Phone _____<br>Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
|--|---|

|   |   |
|---|---|
| Second Insurance _____<br>Group # _____ ID # _____<br>Insured Employer _____<br>Relationship to Insured _____ | Insured Name _____<br>Address _____ City _____<br>State _____ Zip _____ Phone _____<br>Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
|---|---|

|                         |                            |
|-------------------------|----------------------------|
| Emergency Contact _____ | Daytime Phone Number _____ |
|-------------------------|----------------------------|

Are you receiving or have you recently received home health services?  Yes  No  
 Are you receiving or have you recently received other therapy services?  Yes  No Please initial: \_\_\_\_\_

**CONSENT TO TREATMENT:** I consent to rehabilitation and related services at North Valley PT&OT. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. \_\_\_\_\_

**TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. \_\_\_\_\_

**LIABILITY:** I know and agree that North Valley PT&OT is not responsible for loss or damage to personal valuables. \_\_\_\_\_

**WAIVER AND RELEASE:** I hereby release, discharge and acquit North Valley PT&OT, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to North Valley PT&OT and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. \_\_\_\_\_

**NOTICE OF PRIVACY:** I acknowledge receipt of Notice of Privacy Practices. \_\_\_\_\_

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_