

# PATIENT INTAKE AND CONSENT FORM

Internal Use Only: Account #  Account Type  Office #

First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Injury/Onset \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  D  W  
Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Responsible Party \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Relationship to Responsible Party \_\_\_\_\_

Cell Phone \_\_\_\_\_  
Injury Area \_\_\_\_\_  
Accident Related:  Yes  No  
If Accident:  Auto  Work  Other  
Nature of Accident \_\_\_\_\_  
SS# \_\_\_\_\_

Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_  
Contact at Employer \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Insured Name \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
Insured Employer \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_ Insured Sex:  M  F

Second Insurance \_\_\_\_\_ Insured Name \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
Insured Employer \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_ Insured Sex:  M  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 COPPELL SPINE & SPORT. 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 COPPELL SPINE & SPORT is not responsible for loss or damage to personal valuables.

**WAIVER AND RELEASE:** I hereby release, discharge and acquit COPPELL SPINE & SPORT, 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 COPPELL SPINE & SPORT 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 \_\_\_\_\_