PT PLUS
PHYSICAL THERAPY
www.ptplusrehab.com

1503 Washington Lane • Augusta, KS 67010
316 - 775 - 0700 FAX 316 - 775 - 0730

418 N. Andover Road, Suite 400 • Andover, KS 67002
316 - 733 - 0077 FAX 316 - 733 - 9007

PATIENT INTAKE FORM

Primary care Physician: _____ Referring Physician: _____

Work Related Injury? Yes ____ No ____

How did you find out about us?

Direct Mail Your Physician Augusta Gazette Shoppers Guide
Billboard Friend - who _____

In the past 3 months have you had any kind of home health care? Yes _____ No _____
(If yes, please notify the front desk at the time of service)

PATIENT INFORMATION

Legal Name: _____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Date of Birth: _____ Age: _____ SSN: _____

Home Phone: _____ Cell : _____ E-mail Address: _____

Patient Employed By: _____

Business Address: _____

Business Phone: _____ Occupation: _____

SPOUSE INFORMATION OR CARD HOLDER INFORMATION

Legal Name: _____

Same as my information above ☐

Mailing Address: _____ City:_____ State:_____ Zip:_____

DOB: _____ SSN: _____ Cell : _____ Home Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

I do not have medical insurance ☐

URGENT CARE INFORMATION

Emergency Contact (other than spouse) : _____

Address : _____

Relationship to Patient : _____

RELEASE AND ASSIGNMENT INFORMATION

Release of Medical Information: I hereby authorize PT Plus to release my medical information and/ or statement of charges connected with these services to, but not limited to, an insurance carrier, workman's compensation carrier, health and welfare funds, attorneys, consultants, and anyone assisting in obtaining payment.

Insurance Assignment: I hereby assign medical benefits of any type arising out of any policy of insurance, insuring the patient or any other party liable for the patients care to, PT Plus, Inc., to be applied to the charges for services rendered.

Agreement to Pay for Services: For and in consideration of the care and treatment provided to the patient, I agree to pay PT Plus for all charges for services rendered to or on behalf of the patient, including charges for insurance deductible and co-insurance which are not covered by the insurance carrier, workers compensation carrier, health and welfare funds, and fees or charges by attorneys, consultants, and anyone assiting in obtaining payment.

_____ _____

Patient Signature (or legal guardian if under 18 years old) **Date**