Lymphedema Rehab

Patient Intake Form

Patient Info

Name: _____ Sex: M F

DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ (circle) Cell Home Work

Can we leave a message regarding appointments on your voicemail? (circle) Yes No

Email: _____ Marital Status: _____

Occupation:_____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____

Contact Phone Number: _____ (circle) Cell Home Work

Physician Information

Referring Physician: _____

Phone #: _____ Address: _____

PCP (if not referring physician): _____

Phone #: _____ Address: _____

Insurance Information:

Primary Insurance

Insurance Name: _____ Phone #: _____

Name of Insured: _____ ID#: _____

Employer: _____

Group #: _____ Relationship to Patient: _____

Secondary Insurance (if applicable)

Insurance Name: _____ Phone #: _____

Name of Insured: _____ ID#: _____

Employer: _____

Group #: _____ Relationship to Patient: _____

Every insurance company is different and we will do our best to help you determine what is needed for your specific plan. Ultimately, however, it is the responsibility of the patient to ensure they know what is required of their insurance company prior to treatment. If you have Medicare or an HMO plan, you will require a prescription for therapy services prior to Lymphedema Rehab being able to treat you. I understand that I am responsible for knowing my insurance benefit for physical therapy and any limitations or requirements pertaining to it. This includes obtaining a pre-authorization and/or referral, if needed. (Initial here) _____

I hereby authorize treatment and supplies to be rendered by Lymphedema Rehab and their staff and assume financial responsibility for products and services furnished. I hereby authorize Lymphedema Rehab to bill my insurance, and I authorize payment of medical benefits directly to Lymphedema Rehab. I authorize the release of any medical records/information to my insurance company, physicians, and or other related individuals as necessary to process insurance claims and initiate a complaint or appeal for any reason on my behalf. I authorize Lymphedema Rehab to release treatment records to my PCP as well as to my referred physician. I understand that all costs of services, treatment, and supplies not paid by my insurance company will become my responsibly, and I agree to pay. (Initial here) _____

Lymphedema Rehab feels that it is important to protect your privacy. While we must collect personal information to best treat you, we are required by law to protect that information and only disclose it on a need to know basis, such as to your physician(s) and insurance company. A copy of our complete HIPPA and Privacy Policy is available upon request. I acknowledge that I was given the opportunity to access the policy, and was provided a copy (if requested).
(Initial here) _____

Sign: _____ **Date**: _____