



**Comprehensive
Physical Therapy
Center**

Milford (513) 576-6338 x1
Hyde Park (513) 871-5571 x2
Mason (513) 336-7725 x3

Patient Intake Form

Patient Information

Verified DL: Yes No

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	E-mail Address:	
Date of Birth:	SSN:	Sex: <input type="checkbox"/> Male	Marital Status:
<input type="checkbox"/> Female			

Employer Information

Employer Name:	Employment Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
		<input type="checkbox"/> Retired	<input type="checkbox"/> Student
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		

Emergency Contact Information

Contact Name:	Phone Number:	Relationship to Patient:

Physician Information

Name of Referring Physician: _____	Telephone Number: _____
Family Doctor: _____	Telephone Number: _____

Additional Questions

Auto related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No		

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Name of Agency? _____
If Yes, what type of Home Health Services are you receiving? _____		Last date of service: _____
Are you currently residing in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Facility: _____
If Medicare, have you received PT, OT or Speech therapy services since the first of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
-If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient Signature: _____ **Date:** _____

Insurance Information

Only complete the following if the Primary or Secondary policy holder is not the patient. Primary Secondary

Last Name: First Name: Middle Initial: SSN: DOB:

Patient Relationship to Policy Holder: Gender: Male Female

Employer Name: Employer Phone #:

Primary Insurance Section

Secondary Insurance Section

Payor/Plan

Payor/Plan

Policy/ID #:

Policy/ID #:

Group #:

Group #:

I consent to Comprehensive Physical Therapy Center, Inc. for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Comprehensive Physical Therapy, Inc. to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:

Workers Compensation Patient/Guardian Attorney Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer of Comprehensive Physical Therapy, Inc. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information/welcome letter from Comprehensive Physical Therapy Center, Inc.

Client's Signature

Date

I have read and understood Comprehensive Physical Therapy Center, Inc.'s privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

Client's Signature

Date

I have read and understand Comprehensive Physical Therapy Center, Inc.'s billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

Client's Signature

Date

Responsible Party's Signature (if patient is a minor)

Date

Witness Signature

Date