

**Abilene Physical Therapy & Sports Rehab  
Outpatient Therapy Agreement and Intake Form**

Date: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ M \_\_\_ F \_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_

SSN: \_\_\_\_\_ E-mail: \_\_\_\_\_ Marital Status: M S D

Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Parent(s)/Caregiver/POA/Emerg Cont: \_\_\_\_\_ Ph: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_ Primary Dr.: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Condition Being Treated: \_\_\_\_\_ Accident Related?: \_\_\_ Date of Injury: \_\_\_\_\_

If Accident Related List Type: Worker's Comp \_\_\_ Motor Vehicle \_\_\_ Claim #: \_\_\_\_\_

Other (Please Explain): \_\_\_\_\_

<b>Primary Ins:</b> _____
Policy Holder _____
Relationship to Patient _____
ID/Subscriber # _____
SSN _____ DOB _____
Group # _____ Emplr _____
Ph: _____

<b>Secondary Ins:</b> _____
Policy Holder _____
Relationship to Patient _____
ID/Subscriber # _____
SSN _____ DOB _____
Group# _____ Emplr _____
Ph: _____

**Consent:** I give CLINIC consent to provide evaluation and treatment and to use or share my protected health information to obtain payment for my bills or to conduct its healthcare operations and business. I authorize payment to be made directly to CLINIC, including Medicare, Medicaid or other benefits payable from any source, for all services rendered. I understand that I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me. The CLINIC Summary Note of Privacy Practices was given to me. CLINIC is hereby released from all legal liabilities.

CLINIC may not release or share information with: \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Resp. Party's signature (if other than patient):** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

**Eval Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Therapist:** \_\_\_\_\_

<b>Verification for Office Use Only</b>	<b>Date:</b>
Primary Ins Rep: _____ Effective Date: _____ Cal/Cont Yr: _____	
Ded: _____ Met: _____ %Co-Ins: _____ OOP Max: _____ Met: _____	
Copay: _____ Per vis or eval/re-eval Vis Limits: _____	
Accid Inj pd diff: Yes ___ No ___ How? _____	
97033 Yes ___ No ___ \$ Used of \$1840.00 Medicare Max: _____ HMO/MSP/Home health?	
Pre-Auth Required: _____	