PROGRESSIVE STEP REHABILITATION of ORANGE PARK
CONFIDENTIAL PATIENT INTAKE AND CONSENT FORM

Primary Care or Referring physician | Phone Number

PATIENT INFORMATION

Patient's Last name	First	Middle Initial	☐ Mr. ☐ Miss ☐ Mrs . ☐ Ms.	Marital Status (check one) ☐ Single ☐ Married ☐ Div ☐ Wid
Nickname	Date of Birth		Age	Male ☐ Female ☐

Address	City	State	Zip code	Social Security Number	Home Phone No.

Are you employed? ☐ Yes ☐ No ☐ Retired	Occupation	Employers Phone No.
Employer	Employers Address	Cell Phone No.

If Student – School | Sport

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)	Relationship to patient	Home Phone No.	Work Phone No.

PRIMARY INSURANCE

Insurance Company	ID No.	Group No.
Insured Name	Date of Birth	

SECONDARY INSURANCE

Insurance Company	ID No.	Group No.
Insured Name	Date of Birth	

PREVIOUS TREATMENTS

Are you currently receiving Home Health Care for any reason? _____

Have you had Physical Therapy for this diagnosis before? _____ When? _____

Have you had any Chiropractic or Physical Therapy treatment this calendar year? _____

INJURY INFORMATION

Is this problem related to an injury? ☐ Yes ☐ No Date of injury: _____

Is this injury the result of: ☐ Car accident ☐ Home accident ☐ Work ☐ Sports activity ☐ At school Coaches Name: _____

VERIFICATION OF BENEFITS

We will call your insurance company to identify what your benefit plan is, however, please understand that insurance companies will not guarantee medical benefits over the phone. Because it is ultimately your responsibility, we strongly encourage you to consult your benefits book or contact your insurance company directly, in order to understand your plans coverage and limitations. We can only use this information as an estimated guideline in order to collect what your insurance company says in your "responsibility". Actual determination is made after we have received payment or written notification on your claims. If your insurance company makes a determination you do not agree with, it is your responsibility to contact them. Please note we only bill up to 2 insurance plans per claim. Your insurance company may also require a current prescription or pre-authorization from your physician for physical therapy services. Non-compliance with this may result in services not being reimbursed by your insurance company.

Deductible: $_____ Patient Co-insurance _____% Patient Co-pay $_____

Visits allowed: _____ Benefit Maximum: _____