Center for Orthopedic and Sports Physical Therapy
2615 Centennial Blvd., Suite 101
Tallahassee, FL 32308 USA
Phone: 850-656-1837 Fax: 850-877-2917
Email: info@imcpt.com Website:www.imcpt.com

Patient Intake Form

Date: _____

Name: _____
Last First Middle Initial

Date of Birth: _____ **Age:** _____ **Sex:** ❑ **Male** ❑ **Female** **Social Security #:** _____

Contact Information

Address: _____
Street Apartment #

_____
City State Zip Code

Phone Numbers:

Home: _____ **Work:** _____ **Cell:** _____

Appointment Reminders: *(select preferred method)*
❑ Email: _____
❑ Text (provide cell phone carrier): _____

Emergency Contact Information

Name: _____

Relationship: _____

Phone Number: _____

Physician Information

Primary Physician: _____

I was referred by:

❑ Primary MD

❑ Specialist MD: _____

❑ Other: _____

Insurance Information

Primary: _____

Secondary: _____

Tertiary: _____

Please provide only the names of your insurances. We will copy your insurance cards for additional information.

Is your current complaint due to injuries sustained in an AUTOMOBILE ACCIDENT?
❑ Yes (additional forms required)
❑ No

Is your current complaint due to injuries sustained while at WORK?
❑ Yes
❑ No

Date of Onset: _____

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Acknowledgment of HIPAA & Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

The **Notice of Privacy Practices** is posted in the COSPT office showing a more complete description of the uses and disclosures of patient health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Consent to Treatment and Payment

I hereby consent to any necessary medical evaluation and/or treatment for myself, or the below-named minor for whom I am legally responsible. I authorize the release of medical information to any insurance carrier and direct payments to the Center for Orthopedic & Sports Physical Therapy for any examination or treatment rendered. I understand that I am responsible for paying any copayments or patient responsibility balances set by my insurance carrier at the conclusion of each visit. I hereby acknowledge and accept financial responsibility for payment of charges for medical services rendered.

Patient Outcome Data

I agree that my outcome data may be pooled with all other patient data in this clinic, and may be used *anonymously* in presentations and for publishable studies.

Disclosure of Health Information

If you want someone besides you and your doctor (such as a spouse, child, coach, etc.) to have access to your treatment records, please provide their name and relation below.

I authorize the Center for Orthopedic & Sports Physical Therapy clinic to disclose my protected health information to the following persons:

Name Relation to Patient

Please print and sign your name in the box below acknowledging that you have read and accepted the information outlined above.

Patient Name: _____

Parent/Guardian Name (if patient is under 18): _____

Signature: _____ **Date:** _____