



New Patient Intake Form

Patient Information:

Name: _____ Date of birth: _____ Gender: M F
Address: _____ City: _____ State: _____
Zip code: _____ Home phone: _____ Cell phone: _____
Emergency contact: _____
Email: _____ Social Security #: _____
Marital status: _____ Spouse's name: _____
Children's names: _____
Emergency Contact: _____ Phone: _____

Employment information:

Occupation: _____ Employer: _____
Business phone: _____ Employer address: _____
Are you presently working? _____
Whom may we thank for referring you? _____

Workman's Compensation

Employers name _____ Phone: _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Claims Adjustor Name _____ Phone: _____ Claim #: _____
Claim Adjustor Insurance Company Name: _____
Rehab Nurse Name: _____ Phone#: _____ Fax#: _____
Nurse Case Mgmt Co Name: _____ Phone: _____ Fax: _____

Personal Injury

Car Company: _____ Claims manager: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Claim #: _____

ReVIVE HEALTH CENTRE FINANCIAL POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits (*Verification is only a quote) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24-HOUR NOTICE for any cancellation. A fee will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent / legal guardian for all minors.

Patient Signature Date

Parent or Guardian Signature / Print Full Name Date

HIPAA AUTHORIZATION

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

Name / Relationship

Name / Relationship

Name / Relationship