725 N. Wilcox
Castle Rock, CO 80104
(720) 457-5535

NEW PATIENT INTAKE FORM

(Please print neatly)

Today's Date: ____ / ____ / _____ Are you a returning patient? ☐ Yes ☐ No

Who can we thank for referring you?_____

PATIENT INFORMATION

Patient Name: _____ Age: _____ Date of Birth: ____ / ____ / _____

Nickname: _____ SS #: _____ Marital Status: _____ Sex:_____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I hereby give permission for NLPT to leave a detailed message at my:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Do not leave detailed messages

Email Address: _____ Send me email reminders for appointments: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Number: _____

PERSONAL INJURY/WORKER'S COMPENSATION **ONLY**

Injury Insurance/Management Company: _____

Claim #: _____ Date of Injury: _____

Adjuster: _____ _____
Name Phone

Attorney: _____ _____
Name Phone

WORKER'S COMPENSATION **ONLY**

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Employer Phone Number: _____

HEALTH INSURANCE *(for non-Personal Injury/Worker's Compensation)*

Policy Holder: ☐ Self ☐ Other: Policy Holder's Name: _____

Date of Birth: ____ / ____ / _____ Contact Number: _____ Relationship to patient: _____

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NEW PATIENT INTAKE FORM

(Please print neatly)

FINANCIAL POLICY & FEES

Who is responsible for payment? ☐ Self ☐ Other: _____

Please **initial each line below to indicate that you have read and understand each of the following:

_____ 1. INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT. You are responsible for payment of any services rendered that are not covered by your insurance company. Description of benefits is not an authorization or guarantee of payment. Co-pays, co-insurance and remaining deductibles are due at the time of treatment. If your plan has a "coinsurance" this represents a percentage of the total charge per treatment (i.e. 20%, each treatment charge may vary depending on what is done). We will estimate the coinsurance and will require this amount at the time of treatment. If the amount you pay is too much, we will refund the difference once we get your "Explanation of Benefits" from your insurance company. If you underpay, we will bill you for the difference.

_____ 2. No Limits PT requires a minimum of 24-hour notice if cancelling an appointment. You will be charged a $30 missed appointment fee for appointments cancelled or missed without 24-hour notice.

_____ 3. If you are more than 10 minutes late for your appointment, you may be charged a $30 fee and have to reschedule your appointment.

_____ 4. I acknowledge that I have received or was offered a copy of No Limits Physical Therapy's Notice of Privacy Practices.

I understand and agree to follow the above Financial Policy and Fees.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date:_____