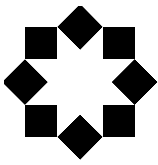

Burkhardt
Physical Therapy Center, LLC

1555 Heritage Blvd.
West Salem, WI 54669
Phone: (608)786-4989 Fax: (608)786-2321 Web: Burkhardtpt.com

Burkhardt Physical Therapy Center LLC

PATIENT INTAKE FORM

Date: _______________

PATIENT INFORMATION:
(Legal) Last Name: ___________________ (**Legal**) First Name: __________________ Preferred Name: ______________
DOB: ________ AGE: _____
Address: ___________________________________ City: ____________________ State: _____ Zip: _____
Phone Numbers: Home Phone: ( ) __________ Cell Phone: ( ) __________ Work Phone: ( ) __________
Social Security Number: ______________________________

Have you had any physical therapy during this calendar year other than at Burkhardt Physical Therapy Center?
☐ **Yes** ☐ **No** **If yes, where? ____**

HOW DO YOU WISH TO RECEIVE YOUR REMINDER CALLS: (circle one?)
NONE TEXT: Carrier Name: ____________________ EMAIL: ____________________CALL: ____________________

EMERGENCY CONTACT:
Last Name: _______________First Name: _______________ Phone: _______________ Relationship: _____________

REFERRAL: Who can we thank for referring you to Burkhardt Physical Therapy Center? _________________________

PROBLEM:
Problem Description: ____ Date of Onset: ___/___/______
Other physicians you are currently being treated by: ____
****

PRIMARY INSURANCE: Insurance: _________________________ ID#: ________________________________
SUBSCRIBER INFORMATION: Subscriber Name: _________________________ DOB: ___/___/______
Subscriber relation to patient: ___Self ___Spouse ___Parent ___Other
SECONDARY INSURANCE: Insurance: _______________________ ID#: ________________________________
SUBSCRIBER INFORMATION: Subscriber Name: _________________________ DOB: ___/___/______
Subscriber relation to patient: ___Self ___Spouse ___Parent ___Other
****

HAVE YOU RETAINED A LAWYER? _______ If yes, name of Attorney?___________________
IS THIS A (*check one*): ☐ **Personal Injury?** ☐ **Auto Accident (*If checked which state):______*** ☐ **None**
****

Patient or Guardian Agreement:
☐ I authorize release of information requested by my insurance plan for payment.
☐ I understand that I am responsible for any balance due.

Signature of patient or guardian: ____ **Date:** ___/___/______

Notice of Privacy Practices:
☐ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of patient or guardian: ____ **Date:** ___/___/______

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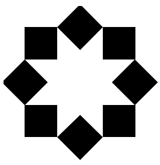

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MISSED APPOINTMENT AND CANCELLATION POLICY

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all patients, the following policies are honored:

24 hour advanced notice is required when cancelling an appointment.

This allows us to offer the appointment time to someone else as we have an extensive waiting list. If you are unable to give us 24 hours advanced notice you will be charged $65.00 for your appointment. This amount must be paid prior to your next scheduled appointment.

No Shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no show". They will be charged for their "missed" appointment.

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Out of respect and consideration to your therapist and other patients, please plan accordingly and be on time.

These policies include physical therapy, personal training and massage appointments.

I acknowledge I have read the above missed appointment and cancellation policy and agree to the terms.

____

(Print Name)

____ **Date:** ______________________

(Signature of patient)

OVER