Burkhardt
Physical Therapy Center, LLC

1555 Heritage Blvd.
West Salem, WI 54669
PH: (608)786-4989
FAX: (608)786-2321
Web: burkhardtpt.com

Burkhardt Physical Therapy Center, LLC

Date: _____

PATIENT INTAKE FORM

PATIENT INFORMATION:

(Legal) Last Name: _____ (**Legal**) First Name: _____ Preferred Name: _____

DOB: _____ Age: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Have you had any physical therapy during this calendar year other than at Burkhardt Physical Therapy Center?

☐ **Yes** **If yes, where? _____**

☐ **No**

WOULD YOU LIKE TO RECEIVE AN APPOINTMENT REMINDER? (Circle one)

NO THANKS! *EMAIL* *CALL* *TEXT (Carrier Name):* _____

EMERGENCY CONTACT:

Last Name: _____First Name: _____ Phone: _____ Relationship: _____

REFERRAL: How did you hear about 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? YES / NO **If yes, name of Attorney: _____**

REASON (PLEASE CHECK ONE) □ **Personal Injury** □ **Auto Accident (*If so, which state):*_____** □ **None**

****

Patient or Guardian Agreement:

☐ I authorize release of my medical 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 read & understand the Notice of Privacy Practices. **Would you like a copy? YES NO**

Signature of patient or guardian: _____ **Date:** _____/_____/_____

OVER

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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, we ask that the following policies are honored:

24 hour advanced notice is required when cancelling an appointment.

This allows us time to offer the appointment slot to other patients in need of our services. If 24-hour advance notice is not received and your vacated appointment time cannot be filled, you will be assessed a $20.00 fee for your missed appointment. This amount must be paid prior to your next scheduled appointment.

No Shows

A patient who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no show". They will be charged a $20.00 fee for their missed appointment.

Late Arrivals

If you arrive late, your session will be shortened in order to accommodate the patient whose appointment follows yours. Out of respect and consideration to your therapist and other patients, please plan accordingly and be on time.

I acknowledge I have read the above policy in full and agree to the terms.

_____

(Print Name)

_____ **Date:** _____

(Signature of patient)

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