OREGON NEUROSPORT PHYSICAL THERAPY
PATIENT INTAKE AND CONSENT FORM

First Name_____MI____
Last Name_____
Address_____
City_____State_____Zip____

Responsible Party_____
Address_____
City_____State_____Zip____

Relationship to Responsible Party_____
Employer_____
Referring Physician_____

Primary Insurance_____
Group # _____ID #_____
Relationship to Insured_____

Secondary Insurance_____
Group # _____ID #_____
Relationship to Insured_____

SSN_____Today's Date_____
Date of Birth_____Age_____
Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W
Home Ph_____Work Ph_____
Cell Ph_____Other Ph_____
Email_____

Injury area_____

If Accident Related: ☐ *Auto* ☐ *Work*
*Date of accident*_____

*Name of Employer*_____
*Phone Number*_____

*Insurance*_____
*Insurance Phone Number*_____
*Insured Date of Birth*_____

Emergency Contact Name_____
Phone Number_____

Are you receiving or have you recently received home health services? ☐ Yes ☐ No
Are you receiving or have you recently received other therapy services? ☐ Yes ☐ No

Please Initial Below

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Oregon Neurosport PT. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may Involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I have resulting from failure to do so. _____

WAIVER AND RELEASE: I hereby release, discharge, and acquit Oregon Neurosport PT its representatives, affiliates, employees, or assigns, of any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services. _____

AUTHORIZATION OF PAYMENT: I hereby authorize my insurance benefits, where applicable, be Paid directly to Oregon Neurosport PT, and **understand that I am financially responsible for non covered services.** _____

NOTICY OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all information provided on this form is true and correct.

Patient/Guardian Signature_____Witness Signature_____