New Patient Intake Form

Biographical Information

Name: _____ **Date:** _____

DOB: _____ **SS#:** _____

Address: _____

_____

Email: _____

Best Phone #: _____ Cell Home Work

If this is not your cell number, please list: _____

Occupation: _____ **Employer:** _____

Spouse/Parent: _____ **DOB:** _____

How did you hear about Upper Valley Rehab: _____

Medical Information

Referring Physician: _____

Primary Care Physician: _____

Insurance Provider: _____ **ID #:** _____

Workers Comp?

Is your injury work related? Y N **Date of Injury:** _____

Insurance handling your claim: _____ **Claim #:** _____

Emergency Contact Information

1) Name: _____ **Relationship:** _____

Contact #: _____

2) Name: _____ **Relationship:** _____

Contact #: _____

Privacy Notice
Acknowledgement & Consent
Cancellation Policy
Insurance & Payment Waiver

NOTICE OF PRIVACY PRACTICES

Upper Valley Rehabilitation, Inc. will not use or disclose patient-identifiable health information outside of the organization and during course of the patient's treatment, except with the patient's consent or authorization, or unless we are otherwise required or permitted by law to do so.

ACKNOWLEDGEMENT AND CONSENT

By signing below, the patient consents to Upper Valley Rehabilitation, Inc.'s use and/or disclosure of their health information as necessary to treat them, to obtain payment for our healthcare services, and to communicate with other healthcare professionals regarding the paitent's treatment. This includes, but is not limited to: referring physicians, insurance companies, law offices retained by the patient, or other appropriate entities as necessary.

CANCELLATION POLICY

Unless 24-hour notice is given, the patient or their representive, is responsible for a $50.00 cancellation fee.

INSURANCE AND PAYMENT WAIVER

Upper Valley Rehabilitation, Inc. will bill the patient's insurance provider for services rendered once we are presented with evidence of current coverage and a doctor's prescription. Until that time, the patient remains responsible for payment of all healthcare services. Any non-covered services, yearly deductibles, or co-payments will continue to be the patient's responsibility. If the patient does not have insurance, or chooses not to use it, we will bill them directly. The patient is accountable for maintaining awareness of their financial responsibilities under their individual health insurance policies.

Payment is expected when services are rendered, unless prior arrangements have been made.

Signature of Patient or Personal Representative	*Date*
Printed Name of Patient or Personal Representative	*Legal Authority of Representative*