The Lifestyle Athlete PLC
South Burlington Physical Therapy

Intake Form

Demographics

First Name | Last Name | Birth Date | SSN

Primary Physician | Referring Physician

Male Female | Male Female | He She They
Biological Sex | Gender Identity | Preferred Pronoun

Street | City | State | Zip

Cell Phone | Home Phone | Email

Preferred Reminder (Circle): Text [redacted] Email

Occupation/Student | Employer/Grade

How did you hear about us?

Emergency Contact

Name | Number | Relationship

Insurance

Primary Insurance Company

ID/Member No. | Group No.

Insured's Full Name | Relationship to Insured

Secondary Insurance Company

ID/Member No. | Group No.

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Please read the following and initial

I agree to release of medical or other information to process claim. I authorize The Lifestyle Athlete PLC to release information from my medical records to insurance companies and their agents for the purpose of determining my medical benefits and for any benefits payable for related services.	
	Initial
I authorize The Lifestyle Athlete PLC to release and receive medical records between Primary Care and/or Referral Physicians and other medical specialists for the purpose of coordinating treatment.	
	Initial
I agree to accept assignment of payment. I understand that in event that my insurance does not pay for services I receive, I will be financially responsible for payment.	
	Initial
I hereby acknowledge that I have read a copy of the practice's Notice of Privacy Practices.	
	Initial
I give the office permission to leave a message on my answering machine.	
	Initial
I give permission to discuss my medical condition with another person. *If yes, please fill out attached HIPPA Form	
	Initial
I understand that failure to show or appointments cancelled under 24 hours are subject to a $30 cancellation fee.	
	Initial

Signature of Patient or Guardian Date

Name Printed

For office use only		
☐ Reviewed by Clinician	☐ Updated Profile	☐ Attached to Case