PEAK
PHYSICAL THERAPY, P.C.
We Get Results!

Boise Clinic
7550 W. Emerald Street
Boise, ID 83704
(208) 375-0666
Fax (208) 375-2996

PATIENT INTAKE FORM

Please Print Legibly

Appointment Date:	
Therapist:	

Personal Information	
Patient Name (Last, First, MI):	
Home Address:	
City, State, Zip Code:	
Home Phone #:	
Work Phone #:	
Cellular Phone #:	
Date of Birth:	
Social Security Number (SSN):	
Gender:	Male Female
Employer:	Is this a work related injury?: Yes No
Employer Address:	
City, State, Zip Code:	
Occupation:	
Marital Status:	M S D W
Emergency Contact:	Name: Phone #:
Email Address:	
Referring Physician:	
Date of injury/surgery:	
Is there an Attorney involved?	Yes No
Responsible Party Information (person to be billed, only if different from above)	
Name (Last, First, MI):	
Address:	
City, State, Zip Code:	
Phone #	
Gender:	Male Female
Social Security Number (SSN):	
Employer:	
Date of Birth:	
Occupation:	
Relationship to Patient (circle):	Self Spouse Parent Other

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Peak Physical Therapy, PC's Notice of Privacy Practices on this day.

Signature:_____ Date:_____

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INSURANCE INFORMATION: Patient Name:_____

Primary Insurance	
Insured's Name:	
Insured's Date of Birth:	
Insured's SSN:	
Insurance Provider:	
Policy #:	
Group #:	
Phone Number:	
Address:	
Policy Effective Date:	
Secondary Insurance	
Insured's Name:	
Insured's Date of Birth:	
Insured's SSN:	
Insurance Provider:	
Policy #:	
Group #:	
Phone Number:	
Address:	
Policy Effective Date:	

Release of Information: Peak Physical Therapy, PC may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Peak Physical Therapy, PC may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Peak Physical Therapy, PC may release all or any part of my record to any federal, state, or local government body when, in the opinion of Peak Physical Therapy, PC such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

Financial Consent: I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Peak Physical Therapy, PC will bill me, my family, and/or other responsible parties for services provided.

Assignment of Insurance Billing: I and/or the responsible party voluntarily assign Peak Physical Therapy, PC and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

No-Show/ Cancellation Policy: All patients who do not cancel their appointment within **24-hours** or more of their scheduled appointment will be charged **$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment within that week. Patients who do not show up to their appointment and do not call to cancel will receive a **$25.00** "No-Show" fee.

_____ _____/_____/_____

Patient Signature/ Responsible Party Date