NORTHWEST SPORT AND SPINE
An Affiliate of IRG Physical & Hand Therapy

PATIENT INTAKE FORM

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____ DOB ___/___/_____

Preferred Name _____ Preferred Pronoun _____

Address _____ Apt#_____ City _____ State _____ Zip _____

Cell Phone (_____) _____-_____ Alternate Phone (_____) _____-_____ ❑ Male ❑ Female

May we leave a detailed voicemail/text message if we are unable to reach you in person? ❑ Yes ❑ No

Email Address _____ *(IRG will not share, sell or trade your information)*

I would like to receive appointment reminders via ❑ Email ❑ Text Message Cell Phone Carrier: _____

Referring Provider _____ PCP _____ Last MD Visit ___/___/_____

How did you hear about our office? *(select all that apply)* ❑ Doctor ❑ Friend/Family ❑ Website/Social Media ❑ ATC/Coach ❑ Community Event/Presentation ❑ Radio/TV ❑ Flyer/Postcard Other: _____

If patient is under 18, name of parent/guardian completing and signing intake paperwork:
Name: _____ Relationship _____ Phone (_____) _____-_____

In case of an emergency, please contact:
Name: _____ Relationship _____ Phone (_____) _____-_____

MEDICAL INSURANCE INFORMATION

Estimate of benefits will be given at check-in.

Primary Insurance: _____ Secondary Insurance: _____

Did your injury or condition occur at work or as a result of a motor vehicle accident? ❑ Yes ❑ No

If Yes: ❑ L&I/Workers Comp ❑ Motor Vehicle Accident Date of Injury ____/____/_____

HIPAA PRIVACY NOTICE

Please check one:

CLICK TO VIEW HIPAA NOTICE

❑ I acknowledge receipt of a copy of the Notice of Privacy Practices

❑ I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information with:

Name: _____ Relationship _____

Name: _____ Relationship _____

CONSENT TO TREATMENT / ASSIGNMENT OF BENEFITS

By signing below:

- I hereby consent to evaluation and treatment (or the evaluation and treatment of my dependent) at Integrated Rehabilitation Group (IRG) & Affiliates.
- I authorize all available medical insurance benefits be directly assigned to Integrated Rehabilitation Group (IRG) & Affiliates for services rendered.
- I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature _____ Date _____

(Parent or Guardian signature if patient is a minor)