2311 S. Kansas Ave. Newton, KS 67114
Tel 316.283.7187 Fax 316.283.7189
www.aptnewton.com

Patient Intake Form Scheduler_______

Today's Date _____/______/_______ Clinic: Newton / Hesston

__ Pt called us __Dr Referral __Walk-in __Reactivate

Script Y / N Dr:_________________ D. A. Y / N PCP:_______________

__Chart made __Pt. scheduled __Dr. scheduled

Eval Date _____/______/_________ **Check-in @** ___________ **Appt @** ___________ **PT** _______ **Appt Confirmed** ________

Paperwork: ____Check-in early ____Pick-up when scheduled ____Emailed ____Mailed

Name ____ DOB _____/______/________ Past Patient? Y / N

Phone _________________________ Diagnosis L / R __________________________Post Op? Y / N Date____/_____/_____

Insurance(s) MC/Supple Humana Coventry MC BCBSKS BCBSOOS Aetna UHC Medicaid Cigna Meritain Self-Pay

OneCall MedRisk VA TriWest Other/Supple Name ____________________________ ID#____________________

WCOMP? Yes / No DOI____/____/____ # of Authorized Visits______ MVA? Yes / No DOA____/____/_____ Atty____________

Notes____

*******NEW PATIENT – Please complete the following information ********

Name ____ DOB ____/_____/________ SS#_________________
(First) (MI) (Last)_

Address ____ City ________________________ ZIP _____________

Phone___________________________ __Mobile __Home Secondary__________________________ __Mobile __Home

Appointment Reminders? _____Text _____Phone Call _____Email Employer: ____________________________

Email ______________________________________ @gmail @yahoo @hotmail @cox.net

Emergency Contact_______________________________ Phone____________________ Relationship_____________________

How did you hear about us? __Previous Patient __Friend/Family __Doctor __Social Media __Newsletter

Insurance Policy Holder (**as it appears on card**) Name____
(First) (MI) (Last)

DOB____/_____/______ Relationship to patient ___________________________ Phone____________________________

Complete if patient is ***under the age of 18 and/or student***

Father Name____________________________________ Mother Name____________________________________

Address_______________________________________ Address____

Phone_____________________ DOB____/_____/______ Phone_____________________ DOB____/_____/______

SS#________________________ SS#________________________

By signing this form, I authorize Advanced Physical Therapy of Newton, LLC to submit medical claims on my behalf to my insurance provider. I understand and acknowledge that submission of claims is not a guarantee of payment and that it is my responsibility to notify Advanced Physical Therapy of any changes to my insurance carrier or coverage as soon as possible. Failure to report such changes will result in the patient being financially responsible or any lapse in coverage or authorization. If for any reason my carrier does not cover any and/or all treatments, I agree that I am responsible for the payment of the entire amount. This includes deductible, co-payment, and/or non-covered benefits. In the event of default, I shall be responsible for all costs of collection and reasonable attorney fees. Furthermore, I authorize payment of medical benefits to which I am entitled, to Advanced Physical Therapy for services rendered. I understand payment is due at the time of service. We accept cash, personal checks, Care Credit, debit, and major credit cards. We reserve the right to charge a $35 insufficient funds fee for returned checks, and a $40 cancellation fee if appointment missed, or cancelled less than 24 hours in advance.

Patient/Patient Representative Signature____ Date____/_____/_______