Complimentary Screening Intake Form

advent PHYSICAL THERAPY

Patient Information

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Insurance Information

Name of Insurance _____

How did you hear about us?

☐ Doctor ☐ Insurance ☐ Mailing ☐ Event ☐ Google ☐ Facebook ☐ Returning Patient

☐ Friend/Family (name) _____ ☐ Other _____

Health Questionnaire

Date of Screening _____

Have you received a screening in the past? ☐ Yes ☐ No If yes, when? _____ Was it for the same injury? ☐ Yes ☐ No

Type of Injury _____ Date of Injury _____

Registration and Waiver

I request Advent Physical Therapy to perform a complimentary screening. I understand the purpose of this screening is to assess my symptoms and suggest a plan of action; it is not a medical examination or diagnosis, nor is it a substitute for a complete physical therapy evaluation. I understand a licensed Physical Therapist will perform the screening, not a Medical Physician. I acknowledge and agree I am responsible for arranging and for obtaining any follow up medical care, with a medical provider of my choice. I am under no obligation to select Advent Physical Therapy for any follow up services, and this screening is not conditioned on my use of any goods or services from Advent Physical Therapy. I have not been offered any special discounts on follow-up services.

I have read, understand and agree to the terms in this agreement. I have been given an opportunity to ask questions, and all of my questions have been answered to my satisfaction. I am signing voluntarily and intend by my signature that this be a complete and unconditional release of all liability to the extent allowed by law. _____ *Initial*

Signature of Patient or Legally Authorized Representative _____ Date _____

Printed Name of Patient or Legally Authorized Representative _____ Date _____

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney (attach documentation) ☐ Other

Explain and Attach Documentation: _____