PATIENT INTAKE FORM

Hanger Clinic
Empowering Human Potential

SECTION 1: PATIENT INFORMATION

PERSONAL INFORMATION

☐ Mr ☐ Ms ☐ Mrs First: ____________ MI: ____________ Last: ____________

DOB: ____________ Sex: ☐ Male ☐ Female Marital Status: ____________ Preferred Language: ____________

Address: ____________ City: ____________ State: ____________ ZIP: ____________

Primary Phone: ____________ Type: ☐ Cell ☐ Home ☐ Work ☐ Other: ____________ Email: ____________

Emergency Contact: ____________ Relation to Patient: ☐ Spouse ☐ Child ☐ Other: ____________

Contact Phone: ____________ Type: ☐ Cell ☐ Home ☐ Work ☐ Other: ____________

Is patient also the guarantor? ☐ Yes ☐ No *If yes, skip to PHYSICIAN INFORMATION.*

Guarantor Name: ____________ Relation to Patient: ☐ Spouse ☐ Child ☐ Other: ____________

Guarantor Phone: ____________ Address: ____________ City: ____________ State: ____________ ZIP: ____________

PHYSICIAN INFORMATION

Referring Physician: ____________ Phone: ____________

Primary Care Physician: ____________ Phone: ____________

CONDITION INFORMATION

Are you diabetic? ☐ Yes ☐ No *If yes, provide the name and address of the physician treating your diabetes.*

Physician Name: ____________ Phone: ____________

Address: ____________ City: ____________ State: ____________ ZIP: ____________

Have you received a similar service in the past 5 years? ☐ Yes ☐ No

Are you in hospice care? ☐ Yes ☐ No

Are you a resident of a skilled nursing facility (nursing home)? ☐ Yes ☐ No

Was your condition the result of an accident? ☐ Yes ☐ No *If no, skip to INSURANCE INFORMATION.*

Was your injury work related? ☐ Yes ☐ No *If yes, provide employer at time of accident.*

Employer Name: ____________ Date of Injury: ____________

Address: ____________ City: ____________ State: ____________ ZIP: ____________

Contact: ____________ Phone: ____________ Claim #: ____________

Was your injury the result of an automobile accident? ☐ Yes ☐ No *If no, skip to INSURANCE INFORMATION.*

Insurance Adjuster Name: ____________ Phone: ____________ Claim #: ____________

SECTION 2: INSURANCE INFORMATION

Please be sure to bring your insurance cards and photo ID to your appointment.

Primary Insurance: ____________ **Policy #:** ____________ **Group #:** ____________

Subscriber Name (if different than patient): ____________

Address: ____________ Phone: ____________

Secondary Insurance: ____________ **Policy #:** ____________ **Group #:** ____________

Subscriber Name (if different than patient): ____________

Address: ____________ Phone: ____________

I certify that the information provided by me is true, accurate and complete.

Signature of Patient/Guarantor: ____________ **Date:** ____________

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Hanger Clinic

PATIENT REGISTRATION SIGNATURE FORM

PATIENT NAME (PLEASE PRINT CLEARLY)	DATE

I understand that sometimes you might need to contact me about my care. By signing this form, I give Hanger Clinic permission to contact me about appointments, treatment instructions, billing, or other care-related issues.

SELECT THE FOLLOWING MODES OF COMMUNICATION HANGER CLINIC MAY USE TO CONTACT YOU (CHECK ALL THAT APPLY)

☐ Voice Messages ☐ Secured Emails/Texts# **OR** ☐ Unsecured Emails/Text Messages#**

HOME PHONE	WORK PHONE	MOBILE PHONE	EMAIL

Revocation of authorization to contact me via email and/or text: I understand that I may revoke my consent for future communications via email and/or text at any time by advising Hanger Clinic in writing. My revocation of authorization will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am entitled.

Authorization for disclosure of Protected Health Information (PHI): I authorize Hanger Clinic to share information regarding my treatment, or payment for treatment, with the following individuals:

☐ SPOUSE OR PARTNER (NAME)		☐ NONE
☐ OTHER INDIIVIDUAL (NAME)	RELATIONSHIP TO PATIENT	

Non-discrimination Notice and Language Assistance Services: Hanger Clinic follows federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. We provide help and information in your language at no cost and offer other tools to make communication easier. If you or someone you are helping needs assistance, speak with our staff, call or text 1-877-442-6434 or email HangerClinicCares@hanger.com.

To obtain this information in other languages, ask our staff for a copy or scan the QR codes.

NON-DISCRIMINATION NOTICE

LANGUAGE ASSISTANCE SERVICES

Your signature below is also an acknowledgement that you have received or have been informed of the opportunity to review a copy of Hanger's Notice of Privacy Practices. You can scan this QR code to view or download a copy.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE
RELATIONSHIP TO PATIENT	
SIGNATURE OF WITNESS (IF PATIENT SIGNED WITH A MARK)	DATE
PRINTED NAME OF WITNESS	

☐ **PATIENT REFUSED TO SIGN FOR RECEIPT OF THE NPP** ☐ **PATIENT IS INCAPACITATED**

☐ **OTHER (PLEASE EXPLAIN REASON FOR PATIENT'S INABILITY/REFUSAL TO SIGN***)**

#Text Communications: I understand that text message charges from my mobile phone provider may apply.
*Unless requested otherwise, emails and texts will be sent encrypted, excluding appointment reminders.
**I understand that sending or receiving personal health information (PHI) through unsecured email or text is not safe because someone else might read it. Hanger Clinic will try to keep these communications private, but they cannot guarantee it will always be confidential.
***Hanger made good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

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