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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PATIENT REGISTRATION SIGNATURE FORM

Hanger Clinic
Empowering Human Potential

Patient Name: (please print clearly): ______________________________

I understand that some circumstances may require you to contact me regarding my care. By signing this form, I authorize Hanger Clinic to contact me regarding appointments, treatment instructions, billing/account information or other matters specific to my care.

Please check which of the following modes of communication Hanger Clinic may use to contact you **(check all that apply)**:

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

Home #: ____________ **Work #:** ____________ **Mobile #:** ____________ **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 otherwise 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 Individual (name): ____________ ☐ Relationship to Patient: ____________

I understand that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Hanger Clinic or any of its subsidiaries for any covered services furnished by Hanger Clinic. I agree to pay Hanger Clinic the deductible and/or coinsurance on my claim. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Campus/TRICARE and its agents, or any private insurance company any information needed to determine these benefits or the benefits payable for related services.

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

Signature of Patient or Responsible Party: ____________ Date: ____________

Signature of Representative (acknowledging receipt only): ____________ Date: ____________

Relationship to the 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 acknowledge that unsecured email/texts are not a secure medium for sending or receiving PHI. There is a possibility that my emails and text messages may be read or otherwise accessed by a third party in transit. Although Hanger Clinic will make a reasonable effort to keep email and text communication confidential and secure, Hanger cannot assure or guarantee the confidentiality of email/text communications.

***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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