Update 09/14/18

INTAKE FORM

Date:____________

Patient Full Name____ Date of Birth _____________ Age:______ Sex: M F

Address: ____ City/State/Zip:____

SSN: ___________________________ Employer/Phone: ____

Cell Phone: _______________________________________ Email Address:____

Emergency Contact Person & Phone:____

Primary Physician:__________________________________ City/State:______________________________ Phone #:_____________________

If patient is a MINOR, parent/guardian's name and signature here: ____

Services I'm Interested in: ❑ Weight Loss ❑ Massage ❑ Yoga ❑ Joint Care Supplements

STRESS Level : 1 low----2----3----4----5 high What's the main cause? ____

NUTRITION: What is your level of nutrition knowledge? ❑ None ❑ A little ❑ Medium ❑ A Lot

SUPPORT STRUCTURE: Who do you have nearby that is close to you? ❑ Family ❑ Friend(s) ❑ None ❑ Other: _______

Name something that is really important to you (or really enjoy doing)? ____

How would you describe your personality? ❑ Social ❑ Emotional ❑ Intellectual ❑ Physical

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How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Facebook ❑ Advertisement ❑ Other: ______________

IMPORTANT RULES & POLICIES

1. Late Policy: If I'm late more than 10-minutes to my appointment, I may be rescheduled or asked to wait for next available open time slot.
2. 24-Hour advance notice is required for changes to my appointment otherwise a $50 fee may apply.
3. Co-pays and/or deductibles are due prior to treatment starts.
4. Not showing for an appointment without notice (or less than 24-hours in advance) will result in a $50 fee added to my account.
5. Cell phones must be shut OFF or silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason you are NOT satisfied with the care received, please call our administrator at (712) 256-1800.

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Flex Physical Therapy and the physical/occupational therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Flex Physical Therapy, and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Flex Physical Therapy, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Flex Physical Therapy and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Flex Physical Therapy.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE FLEX PHYSICAL THERAPY FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: ____ Signature____ Date:__________