# NEW PATIENT INTAKE FORM

(Please print neatly)

**Name:**_____ **Date of Birth:**_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Email:**_____ **Cell Ph:**_____ **Home Ph:**_____

**Sex:** ☐ Male ☐ Female **Primary Care Doctor:**_____

**Emergency Contact:**_____ **Parent/Legal Guardian** (if applicable):_____

**Phone #:**_____ **Phone #:**_____

**Issue today:** _____

**Date of Onset:**_____ **Is this Auto or Work related?** ☐ Yes ☐ No

## Medical History:

**Allergies:** _____

**Medications:** _____

**Surgeries:** _____

**Tobacco:** ☐ Never ☐ Currently ☐ Former **Vaping:** ☐ Never ☐ Currently ☐ Former

**Alcohol:** ☐ None, Or #_____ drinks per ☐ Day ☐ Week ☐ Month, ☐ Year

| | **Patient History** | **Family History (siblings, parents, grandparents)** |
|---|---|---|
| Diabetes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Hypertension (high blood pressure) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| High Cholesterol | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Heart Attack | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Other Heart Disease/Heart rhythm issue | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Stroke | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Pacemaker or Defibrillator | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Memory/Dementia/Alzheimer's | ☐ Yes ☐ No | ☐ Yes ☐ No |
| CKD-Chronic Kidney Disease **or** Dialysis | ☐ Yes ☐ No | |
| Asthma | ☐ Yes ☐ No | |
| COPD/Emphysema | ☐ Yes ☐ No | |
| Sleep Apnea | ☐ Yes ☐ No | |
| Oxygen | ☐ Yes ☐ No | |
| Neck problems | ☐ Yes ☐ No | |
| Back problem | ☐ Yes ☐ No | |
| Seizure Disorder | ☐ Yes ☐ No | |
| Currently Pregnant | ☐ Yes ☐ No | |
| Learning Disability | ☐ Yes ☐ No | |
| Significant Hearing or Vision Problem | ☐ Yes ☐ No | |

Other—List: _____

I certify that the information provided is, to the best of my knowledge, true and accurate.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

**Patient Name:** _____

**Date of Birth:** _____

## Statement of Financial Responsibility:

Claymont Walk-In Care appreciates the confidence you have shown in choosing us to provide for your needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **However, you are ultimately responsible for the payment of your bill.**

You are responsible for payment of any co-payment at the time of service and for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulation that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part for your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the office, mailed to the address on your statement, or you may access our on-line bill payment option once a statement is received from the billing office, or by calling our customer service department at 302-317-1531.

Your insurance company requires Claymont Walk-In Care to collect your co-payment amount from you at the time of service. I f we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Furthermore, we have an obligation to collect any co-insurance %percentage or unmet deductible amounts from you that are determined to be your responsibility.

You will receive statement from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payment received from both you and your insurance company.

I have read the above policy regarding my financial responsibility to Claymont Walk-In Care for providing services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Claymont Walk-In Care. I agree to pay Claymont Walk-In Care the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

## Consent to Treatment:

I am aware of my diagnosis and voluntarily consent to have Claymont Walk-In Care, through its appropriate personnel, provide evaluation and recommendations, and/or treatment by the provider. I understand that the treatment I receive from Claymont Walk-In Care is limited and that I shall seek treatment from other medical professionals for all other issues or ongoing symptoms I may experience. I understand that I have the right to ask questions at any time during the course of my care.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

**Patient Name:** _____

**Date of Birth:** _____

## Notice of Privacy Practices:

I acknowledge that the **Notice of Privacy Practices** and **Notice for Federal Civil Rights** is posted at the location in which I am receive treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

## Authorization to Release Information:

I authorize Claymont Walk-In Care to release to appropriate agencies, any information acquired in the course of my, or the above-named patient's, examination and treatment, necessary to secure payment for services provided.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

## Authorization to Utilize Contact Information:

I agree that in order for Claymont Walk-In Care to collect any amount I may owe, Claymont Walk-In Care may contact me by any telephone number associated with my account, including wireless telephone number, which could result in charges to me. We may also contact you by sending text messages or emails, using any email address I provide to Claymont Walk-In Care.

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____

## Authorization to Share Your Treatment Information with Family or Friend:

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information, or billing information. Please take a few moments to complete this section.

I authorize Claymont Walk-In Care to disclose my health information, that is directly related to my current treatment at Claymont Walk-in Care, to the individual(s) listed below, for purposes of their role in my home treatment or payment for the health services that I have received.

**Name:**_____ **Relationship:**_____
**Name:**_____ **Relationship:**_____

**Signature:** _____ **Date:** _____

Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ other: _____