Date: _____

Physical Therapy Specialists

Spine and Sports Rehab, Weight Loss and Wellness Center

PATIENT INFORMATION

How did you hear about us? _____

Primary Care Physician _____

Referring Physician _____

Name _____ Sex M / F Marital Status M / D / S / W
Last First M.I.

Address _____ City _____ State ____ Zip _____

Home Phone _____ Emergency Contact _____ Ph # _____

Social Security _____-_____-_____Driver's License _____ Date of Birth _____

E-Mail Address _____Are you a previous patient? ___Yes ___No

Employed By _____ Phone # _____ Ext. _____

Employer Address _____ City _____ State ____

Name of Spouse or Parent _____ Relationship _____

Date of Birth _____ Social Security _____-____-_____ Phone # _____

Employed By _____ Employer Phone _____

MEDICAL INFORMATION

Part of body to be seen (Part and side of body)	What type of injury? ☐ Auto Accident ☐ Non-Accident ☐ Industrial ☐ Other
Onset of symptoms or date of accident	Where did injury occur?
Was there any time lost from work? ☐ No ☐ Yes From _____ to _____	Any notable medical problems (you may cont. on back) ☐ No ☐ Yes Describe:_____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Insurance Company _____	Insurance Company _____
Insurance Phone _____	Insurance Phone _____
Member ID # _____	Member ID # _____
Policy Holder Name _____	Policy Holder Name _____
Birthdate _____	Birthdate _____
Group # _____	Group # _____
Relationship to Patient _____	Relationship to Patient _____

INDUSTRIAL INFORMATION

Industrial Carrier _____ Adjustor _____ Phone _____

Address _____ Claim # _____ Injury Date _____

Attorney -_____ Phone # _____

Address _____ City _____ State _____

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO **PHYSICAL THERAPY SPECIALISTS** ALL MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY. I HEREBY AUTHORIZE TREATMENT FOR MY MEDICAL CONDITION. I ALSO ACKNOWLEDGE RECEIPT OF THE HIPPA NOTICE AND ADVANCE BENEFICIARY NOTICE REGARDING MEDICAL SUPPLIES AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED FOR CONTINUITY OF CARE.

X _____ **X** _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF INSURED

Physical Therapy Specialists
Spine and Sports Rehab, Weight Loss and Wellness Center

CONSENT FORM

I give Physical Therapy Specialists my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the Physical Therapy Specialists is not required to agree to the request. If Physical Therapy Specialists agrees to my requested restriction, they must follow the restrictions(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name _____ Date _____

Signature_____
(Patient, parent, or legal guardian)

If signed by parent or legal guardian, state relationship to patient_____