**Thank you for providing the following information below so that we can provide you the highest quality care and service possible.**

**Consent:** I authorize the medical provider to render Physical Therapy as deemed medically necessary.

Initial \_\_\_\_\_\_\_

**Records Release:** I authorize the release of any private health information necessary to process my claims or provide continuation of medical care. Initial \_\_\_\_\_\_\_

**Were you referred by a physician?** **Yes or No (circle one)** If yes, please list the name of the provider who referred you so we can thank them for the referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**If your physician did not refer you, how did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Do you have a primary care physician? Yes or No (circle one)** If yes, please list the name of your primary care physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Is it ok if we contact your PCP regarding your plan of care during your treatment with us? Yes or No (circle one)

**Cancellation Policy:** $50.00 fee for appointment no-shows or Cancellations with less than 24 hours’ notice.

**Email Policy**: We will NEVER give or sell your email address. You can unsubscribe from occasional messages at any time.

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it OK to send billing statements to this email? Y N **Appointment Reminders:** I would like to receive TEXT reminders:

**TEXT MESSAGE**: Cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell carrier (circle one) VERIZON T-MOBILE SPRINT AT&T OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INJURY DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you received any other physical Therapy this year (2019): Y N**

**If Yes, how many visits of PT, have you received this year \_\_\_\_\_\_\_\_\_\_\_\_\_**

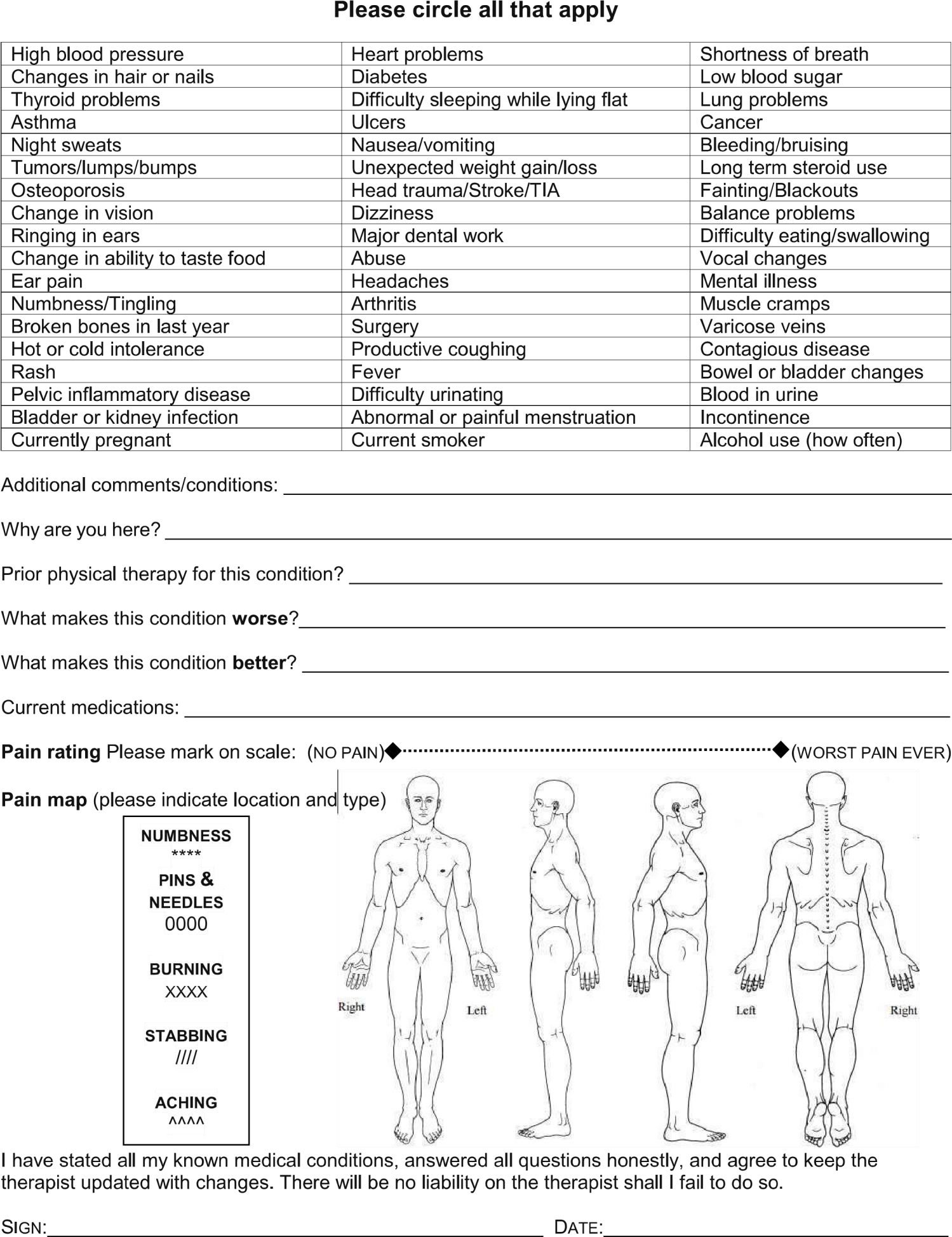
**IS YOUR INJURY:** (PLEASE CIRCLE) WORK RELATED AUTO RELATED NOT APPLICABLE

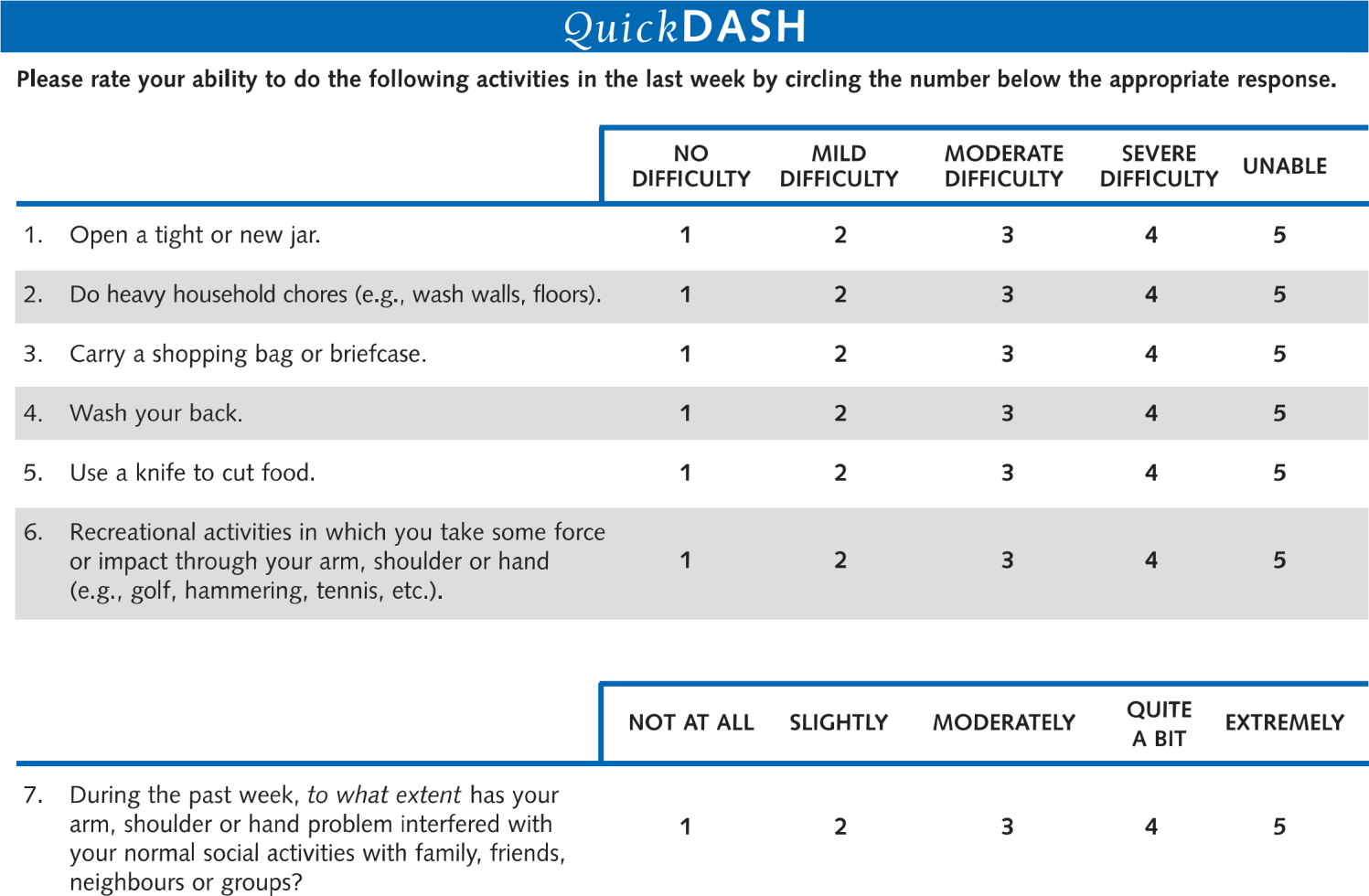
ADJUSTER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADJUSTER PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ATTORNEY NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ATTORNEY PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





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