

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 _____ <small style="display: flex; justify-content: space-between; width: 100%;">Last First M.I.</small>	Sex M / F Marital Status M / D / S / W
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Auto Accident <input type="checkbox"/> Non-Accident <input type="checkbox"/> Industrial <input type="checkbox"/> Other
Onset of symptoms or date of accident _____	Where did injury occur? _____
Was there any time lost from work? <input type="checkbox"/> No <input type="checkbox"/> Yes From _____ to _____	Any notable medical problems (you may cont. on back) <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____

INSURANCE INFORMATION	
<u>Primary Insurance</u>	<u>Secondary Insurance</u>
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 _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

X _____
SIGNATURE OF INSURED



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 _____