PALM COAST
PHYSICAL THERAPY
& SPORTS REHABILITATION CENTER

Name:_____ Date of birth:____/____/____
(last) (first) (M.I.)

Marital Status: M D S Other Gender: M F

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

Phone: (home) _____ (cell)_____ E-Mail address:_____

Primary Insurance:_____ Group/ID #:_____

Ins Subscriber's full name:_____ Ins Subscriber's SS# & date of birth _____

Please list any other insurance:

Secondary insurance:_____ Group/ID #:_____

Emergency contact:_____ Emergency contact number:_____

Referring MD:_____ Primary care physician:_____

Employer:_____ Phone (work):_____

Are you currently receiving home health care? Yes No

If YES, who is the agency and what is the phone number: _____

Did a family member or friend recommend us to you? Y N If yes, who was the treating PT? _____

If no, how did you choose us for your physical therapy? Radio Print Ad MD Location Website

Yellow pages Insurance Other:_____

Is your injury/condition a result of a work related incident? Yes No

Workers' Compensation Only

Ins Co:_____ Address:_____ City:_____ State/Zip_____

WCB#: _____ Claim #: _____ Phone #:_____

Date of Injury/accident:_____ Employer:_____ Employer contact:_____

Employer ph #:_____ Attorney:_____ Attorney ph #:_____

I, _____ hereby authorize and instruct my insurance carrier to pay Palm Coast Physical Therapy, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

_____ _____
Insured or Authorized Person's Signature Date

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PATIENT MEDICAL HISTORY

Name: _____ Date _____

Height: _____Weight: _____

Please rate your pain from 0 to 10: _____

What is your primary reason for today's appointment?:

_____

Please briefly describe your symptoms :

_____

_____

Onset Date: _____Duration: _____

Please check below all that apply:

- ☐ Allergies
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Vascular problems
- ☐ Migraines
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Diabetes (list type below)
- ☐ Arthritis (list type below)
- ☐ Asthma/Breathing problems
- ☐ Epilepsy or seizures
- ☐ Immunocompromised
- ☐ Chest pain/angina
- ☐ Pacemaker
- ☐ Smoke
- ☐ Cancer
- ☐ Surgeries
- ☐ Dizziness/fainting
- ☐ Currently pregnant?

Due date:_____

Please explain any checked above: _____

_____

_____

If you have any other medical conditions your therapist should be made aware of please list:

_____

_____

Current Medications:

_____

Patient signature: _____Date: _____

(Parent or Guardian if under the age of 18)

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Patient Information Consent Form Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Palm Coast Physical Therapy & Sports Rehabilitation Center. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Palm Coast Physical Therapy & Sports Rehabilitation Center for services rendered. Palm Coast Physical Therapy & Sports Rehabilitation Center will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand Palm Coast Physical Therapy & Sports Rehabilitation Center's Notice of Information Practices. I understand that Palm Coast Physical Therapy & Sports Rehabilitation Center may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Palm Coast Physical Therapy & Sports Rehabilitation Center will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Palm Coast Physical Therapy & Sports Rehabilitation Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Palm Coast Physical Therapy & Sports Rehabilitation Center has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature _____Date_____

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. If you do not call at least 6 hours (during business hours) prior to your appointment time, there will be a **$25 late cancel fee**. Failure to call or show for an appointment will result in a **$50 No Show fee**.

Patient Signature _____Date_____