
## PATIENT INFORMATION

**LAST NAME:_____ FIRST NAME_____**

**DATE OF BIRTH:_____ AGE:_____ SEX_____**

**ADDRESS:_____ CITY:_____ STATE____ ZIP_____**

**PHONE:_____ DATE:_____ EMAIL:_____**

**PRIMARY CARE PHYSICIAN:_____ PHONE:_____**

**REFERRING PHYSICIAN:_____ PHONE:_____**

**PHARMACY NAME & ADDRESS_____**

**EMERGENCY CONTACT (NAME):_____ PHONE:_____**

## INSURANCE INFORMATION

**PRIMARY INSURANCE COMPANY:_____**

**INSURANCE ID#:_____ GROUP#:_____**

**SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____**

**SECONDARY INSURANCE COMPANY:_____**

**SECONDARY INSURANCE ID#_____GROUP#:_____**

***IF PATIENT IS UNDER THE AGE OF 18, ENTER THE FOLLOWING INFORMATION**

**NAME OF PARENT/GUARDIAN RESPONSIBLE:_____**

## MEDICAL HISTORY

**REASON FOR THERAPY:_____**

**IS THIS DUE TO AN ACCIDENT? YES_____ NO_____IF YES,WHEN?_____**

**HAVE YOU BEEN TREATED FOR THIS CONDITION PREVIOUSLY? YES_____NO____**

**IF YES, BY WHOM?_____**

**ARE YOU CURRENTLY RECEIVING NURSING/HOME HEALTH SERVICE COVERED BY INSURANCE? YES____ NO____**

**PLEASE LIST ANY ALLERGIES:_____**

**_____**

**PLEASE LIST CURRENT MEDICATIONS:_____**

**_____**

**_____**

**_____**

## PAST MEDICAL HISTORY (CHECK ONLY WHAT APPLIES)

**___AIDS/HIV ___ANGINA ___ANXIETY ___ARTHRITIS ___ ASTHMA**

**___AFIB ___BIPOLAR DISORDER ___BLOOD CLOTS ___BREAST DISORDER**

**___CANCER ___CHRONIC FATIGUE ___CONGESTIVE HEART FAILURE**

**___COPD ___DEPRESSION ___DIABETES ___DVT ___FIBROMYALGIA**


**___GASTROINTESTIONAL BLEED ___GLAUCOMA ___GOUT ___HEADACHES**

**___HEART DISEASE ___HEARTBURN/REFLUX ___HEPATITIS ___STROKE**

**___HIGH BLOOD PRESSURE ___HIGH CHOLESTEROL ___KIDNEY STONES**

**___HEART ATTACK ___OSTEOPOROSIS ___SEIZURES ___STOMACH ULCERS**

**___THYROID DISEASE**

**PLEASE LIST ALL PAST SURGICAL PROCEDURES AND YEAR:_____**

**_____**

**_____**

**DO YOU CURRENTLY HAVE ANY PAIN, STIFFNESS, WEAKNESS OR FUNCTIONAL DIFFICULTLY INVOLVING YOUR HAND,WRIST, OR SHOULDER? YES___ NO___**

**IF YES, WOULD YOU LIKE TO BE EVALUATED BY OUR OCCUPATIONAL THERAPIST? YES___ NO___**

**ARE YOU INTERESTED IN LEARNING MORE ABOUT INTEGRATIVE DRY NEEDLING AS PART OF YOUR TREATMENT? YES____ NO____**

**CANCELLATION POLICY**

**We request that you please give our office at least 24hour notice in the event that you need to reschedule/cancel your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you may be charged a $50.00 fee. Additionally, you may be offered limited appointment times. Repeated offenses with result in dismissal from the practice.**

**SIGNATURE:_____ DATE:_____**

# NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

SIGNATURE: _____

DATE: _____

# INFORMED CONSENT TO TREATMENT

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certified to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this business of physical therapy. I authorize this office and staff to examine and treat my condition as a doctors see fit. I hereby authorize the doctors/staff to release all my information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that the health insurance policies are in arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature:_____

Date:_____

# Credit Card Authorization Form

At Florida Strong PT we require keeping a credit card on file to streamline the payment process, ensuring that all financial transactions related to your care are handled efficiently and securely. This policy allows us to focus more on providing high-quality physical therapy services by reducing administrative time spent on billing and collections. It also helps in minimizing the risk of interrupted care due to outstanding balances.

**Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.**

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ CVV_____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

Please be assured that your credit card will only be charged after the submission of claims to your insurance company and the determination of your responsibility for any co-pays, deductibles, or in the case of missed appointments without proper notice, per our cancellation policy. You will be notified of any charges in advance, and detailed receipts will be provided for all transactions processed using your credit card.

_____ _____

Customer Signature Date