Grapevine Physical Therapy
And Sports Medicine

Patient Information

Date _____

Name _____ Age _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell # _____ Email: _____ Marital Status _____

Employer _____ Phone _____ Full time, Part time, Unemployed

Work Address _____ City _____ State _____ Zip _____

Occupation _____

Name of Spouse/Parent _____ Phone _____

Who may we contact in case of an emergency? Name _____ Phone _____

Referring Physician _____

Date of Injury or when symptoms first appeared _____
Were you injured on the job? Y ___ N ___
Is this injury the result of a car accident? Y ___ N ___
Due to this injury, are you in legal proceedings? Y ___ N ___

Describe your injury or symptoms _____

_____

Responsibility and Authorization Agreement

I agree to receive physical therapy services provided by Grapevine Physical Therapy and its staff as prescribed by my physician in accordance with applicable laws in the State of Texas. I have been given the opportunity to ask questions regarding my diagnosis and treatment options and I understand that I may refuse treatment at any time

I release and hold harmless Grapevine Physical Therapy and its staff or agents from all claims and liabilities that may arise as a result of any claim of any nature resulting from my treatment or care.

I authorize Grapevine Physical Therapy to release and request information regarding my health or treatment from any necessary agency deemed appropriate. I further authorize any insurance company associated with myself to pay proceeds or any benefits due me directly to Grapevine Physical Therapy. Payment for services rendered is due at the time of service, unless prior arrangements have been made. Any patient balance over 60 days old will be turned over to a collection agency. I understand that I am responsible for all charges and services rendered to me. I have a contract with my insurance company and the ultimate responsibility for payment is mine.

I have read AND understand the above Agreements:

Patient, Parent/Guardian Signature _____