



Please complete to the best of your ability and return prior to your session.

Contact Information

Client Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

Phone Number: (____) _____ E-mail: _____

I give permission to be contacted for purpose of appointment reminders, communication with PT, and sending exercises and treatment recommendations by: *(please mark/circle)* E-MAIL PHONE TEXT

Emergency contact: _____ Phone Number: (____) _____

Medical History

Allergies: _____

Current medications: _____

Current or Previous Medical Diagnoses: _____

Reason for Visit - Please briefly describe reason(s) for visit and goals for the session(s):

Acknowledgement and Agreement of Policies *(All forms available at www.AmbitionPT.com)*

- I consent to receive physical therapy diagnostic evaluation and treatment from Physical Therapist of Ambition Physical Therapy & Wellness, LLC. I certify that no guarantee has been made as to the result of any treatment or care administered.
- I have received, read, and understand the forms "Patient Agreement" and "Notice of Privacy Practice" for Ambition Physical Therapy & Wellness, LLC and agree to their terms.
- I understand that Ambition Physical Therapy & Wellness, LLC is fee-for-service and payment is expected on the day of service provided, at a rate of \$150 per visit (pricing valid for 1 year from date below). I am responsible for all charges. I understand that Ambition Physical Therapy & Wellness, LLC will not submit payment for any insurance reimbursement and is not a Medicare or Medicaid provider.
- I agree to all terms and policies of Ambition Physical Therapy & Wellness, LLC.
- I attest that I have told provider of Ambition Physical Therapy & Wellness if I have tested positive for, come in contact with someone who has tested positive for, or have symptoms consistent with COVID-19 in the 10 days prior to my appointment.

Signature: _____ **Date:** _____

Thank you for your time! I look forward to working with you to achieve your goals! Tessa