Physical Therapy Specialists
397 Palm Coast Pkwy SW, Unit 4
Palm Coast, FL 32137
Phone (386) 447-0610 * Fax (386) 447-0670

_____ □ Male □Female
LAST NAME **FIRST NAME** **MIDDLE NAME**

Age _____ Birth Date _____ Marital Status (**circle one**) S M D W

Home # (_____)_____ Work # (_____)_____ Cell # (_____)_____

Home Address_____

Mailing Address _____
(If Different From Home Address)

E-Mail Address _____

Spouse's Name _____ Cell # (_____)_____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

Primary Doctor _____ City/State _____ Phone # (_____)_____

Who referred you to our practice? _____ Phone # (_____)_____

Have you or any of your family members had services here before? □ No If yes, give name _____

Financial Responsibility Agreement and Signature Authorization

I authorize Physical Therapy Specialists, LLC to administer physical therapy care as necessary, to use and disclose my protected health information for the purposes of treatment and payment. Physical Therapy Specialists, LLC will file my insurance as a courtesy on my behalf. I request that payment of authorized Medicare or any insurance benefits be made payable to Physical Therapy Specialists, LLC. I authorize any medical information or documentation about me in their possession be released to the Centers of Medicare Services (CMS) or any insurance carrier, their agents and carriers as needed to determine these benefits or the benefits payable for related services, now or in the future. I agree to be financially responsible for all therapy charges and services rendered to myself whether or not covered by my insurance. I accept responsibility for any balance not paid by my insurance company if not paid in 45 days. There will be a $30.00 fee on all returned checks. I agree to any costs of collections if not paid within 45 days. I agree to contact Physical Therapy Specialists in the event my insurance and/or contact information changes. I have received and agree to the terms and conditions set by Physical Therapy Specialists Financial Policy.

Print Name_____ Signature_____ Date_____

Acknowledgment of Receipt of Notice of Privacy Practices Consent for Use and Disclosure (HIPAA)

Our practice has implemented a program of Health Information Privacy Policies and Procedures to protect the interest of your, our valued patients. These are based on the requirements of the Health Insurance Portability and Accountability Act, (HIPAA), under the Department of Health and Human Services. This act establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. All health care providers are required to post this notice and to make a good faith effort to obtain consent from their patients. This consent form is legally necessary for us to assist you with, but not limited to, tasks such as insurance pre-approval and filings, medical consultations, if necessary, laboratory coordination, appointment reminders, and requests for radiology or surgical reports as necessary.

As required by the Health Insurance Portability and Accountability Act, (HIPAA), I hereby acknowledge that I have received a current copy of Physical Therapy Specialists "Notice of Privacy Practices" and it has been explained to my satisfaction. I am aware that Physical Therapy Specialists included a provision reserving the right to change the terms of its notice and to make new provisions effective for all protected health information it maintains.

Patient Signature: _____ Date: _____
If a personal representative is required, please complete the following:

Name:_____ Signature: _____ Date: _____

Relationship to patient: _____

Patient Medical History

Name: _____ What caused the injury or condition? _____

Height _____ Weight _____ Date of Injury or onset of condition: _____ Is it currently: Better Worse Same

What do you hope to accomplish through physical therapy? _____

Please list all previous surgeries

Surgery	Date	Surgery	Date

Please list all current medications

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Do you have any known allergies? No Yes (explain) _____ Do you Smoke? No Yes (how much/day) ____

Is there any medical reason you should not exercise? No Yes (explain) _____

Have you had, or do you presently have any of the following?

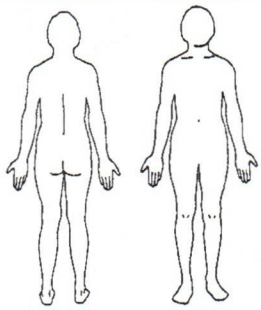
	Yes	No
Heart Disease		
High Blood Pressure		
Arthritis		
Difficulty Breathing		
Lung Problems		
Liver Disease		

	Yes	No
Diabetes		
Cancer		
Thyroid Disease		
Seizures		
GI Problems		
Stroke/Head Trauma		

	Yes	No
Knee Pain		
Hip Pain		
Shoulder Pain		
Headaches		
Other		

Are you pregnant or do you think that you could be pregnant? _____ Yes _____No

Please place an "X" on the area(s) of the body diagram which are painful to you



On a scale of 1 to 10, with 0 meaning no pain and 10 meaning the worst pain you can imagine, how much pain have you had in the last 24 hours?

0 1 2 3 4 5 6 7 8 9 10

Describe your pain (Check more than one if applicable) _____Continuous _____Occasional _____Aching _____Burning

_____Sharp _____Dull _____Numbness _____Tingling Other: _____

Have you had: _____X-ray _____CT Scan _____MRI Scan _____Epidural Block Other:_____

Please sign and date verifying that the answers given are to your best recollection

_____ _____

Signature Date