**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Last Preferred

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Male**□** Female **□**

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Primary Phone #: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other #: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave voicemails regarding appointments on number(s) listed above? Yes □ No □

We offer an appointment time reminder service. Please make selection below:

**Text message reminder: □**

**E-mail reminder: □**  E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guarantor Information**

Parent/Guarantor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Primary Phone #: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other #: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a work-related injury? Yes □ No □**

If yes, work-comp company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a motor vehicle injury? Yes □ No □**

If yes, insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State where accident occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient medical History:**

(Please list any surgeries, current medications, or diagnosis that pertain to your physical therapy visit)

**Body Mass Index Values**

Please refer to our body mass index chart located on your clipboard and enter your corresponding values.

**Height: Weight: BMI:**

**HIPAA and Privacy Practices**

I, **\_\_\_\_\_\_\_** give this practice/clinic my consent to use or disclose my health information to coordinate my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I have been informed that I may review the practice/clinic full Privacy Practices (for a more complete description of uses and disclosures) before signing the consent. I understand that the practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction they must follow the restriction(s). I also understand that I may revoke this request at any time, by making a request in writing, except for information already used or disclosed.

**Responsibility of Bill**

I, **\_\_\_\_\_\_\_\_\_** authorize treatment and agree that I am financially responsible for all charges incurred through this office, regardless of insurance or third-party liability and all proceeds of insurance are assigned to this office. I also request payments of government benefits either to myself or to third party who accept assignment. I authorize Florence Therapy and Wellness, Inc. to provide health care information concerning my medical condition to my insurance company or third-party payer. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the named insurance carrier(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or the above-named carrier at any time. I certify that I represent only myself or individuals for who I am guardian and am not here on behalf of a third party. I authorize treatment by any or all providers and professional staff affiliated with Florence Therapy and Wellness, Inc

A picture containing diagram

Description automatically generated**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Signature Date**