SPORTS & WELLNESS PHYSICAL THERAPY

## PEDIATRICS PATIENT INFORMATION AND CONSENT FORM - PT

Name:_____ Circle: M/F Date:_____
Last First MI

Social Security Number:_____ Birthdate:_____Age:_____

Parent/Guardian Name:_____ Relationship to Patient: _____

Parent/Guardian Name:_____ Relationship to Patient: _____

Address:_____
Street City State Zip

E-Mail Address: _____

*Your email address will be used for appointment reminders.* ***Check here if you prefer reminders via automated phone call*** ☐ ***or text*** ☐

*It may also be used to send periodical newsletters and information about upcoming events.* ***Check here to opt out*** ☐

Phone: Home_____ Work:_____Cell:_____

Emergency Contact Person:_____ _____ _____
Name Relation Phone

## RESPONSIBLE PARTY EMPLOYMENT INFORMATION

Name of Responsible Party:_____Relation to Patient:_____

Social Security Number:_____DOB:_____

Employer:_____Job Title:_____

Address:_____
Street City State Zip

Phone: Home_____ Work:_____Cell:_____

## INSURANCE

**TYPE:** Private_____ Medicare_____Auto_____ Worker's Comp_____ Other_____
(check) Specify

Primary Insurance Company:_____
Address:_____Phone:_____
Agent/Adjuster:_____
Policy #:_____ Group #:_____
Insured's Name(if different from patient):_____
Secondary Insurance Company:_____
Address:_____Phone:_____
Policy #:_____Insured's Name:_____

## PHYSICIAN

Name of Referring Physician:_____

Name of Family Doctor (if different):_____

Reason for Physical Therapy:_____Is therapy due to a car accident? Yes No

Date of Injury(**please list**-approx.ok):_____Any Previous PT for Current Problems? Yes No

What other treatments have been tried? The outcome?_____

_____

## HISTORY

Do you now have/or have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | YES | NO | Sensitive to Heat/Ice | YES | NO |
| Heart Disease | YES | NO | Allergies | YES | NO |
| Heart Attack | YES | NO | Hernia | YES | NO |
| Pacemaker | YES | NO | Seizures | YES | NO |
| Diabetes | YES | NO | Metal Implants | YES | NO |
| Headaches | YES | NO | Dizzy Spells | YES | NO |
| Kidney Problems | YES | NO | Balance Problems | YES | NO |
| Nervous Disorder | YES | NO | Vision Problems | YES | NO |
| Hearing Problems | YES | NO | Cancer | YES | NO |
| Speech Problems | YES | NO | Prior Hospitalizations | YES | NO |

If YES on any of the above, please explain and give approximate dates_____

_____

Are you presently taking any medication? List_____

List any other areas of concern:_____

_____

Do you have difficulty with any of the following activities (check all that apply; if checked, please be specific. i.e. time limits, distance, weights, etc.)

Sitting_____ Sleeping_____
Standing_____ Personal Care_____
Walking_____ Lifting_____
Driving_____ Other_____

List any past surgeries and date of surgeries:_____

_____

What benefits do you expect to gain from physical therapy? Be specific:

A._____
B._____
C._____

**The above information is correct to the best of my knowledge.**

I have read and fully understand Sports & Wellness Physical Therapy's **HIPAA Notice of Information Practices**. I understand Sports & Wellness Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand Sports & Wellness Physical Therapy will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sports & Wellness Physical Therapy's **HIPAA Notice of Information Practices**. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby consent to treatment and authorize my insurance company to pay directly to Sports & Wellness Physical Therapy medical benefits otherwise payable to me, and I will be responsible to Sports & Wellness Physical Therapy for all expenses incidental to treatment rendered not paid under this plan. **I understand a Cancellation Fee of $50 may be charged if I cancel an appointment with less than 24 hours' notice or fail to show up for an appointment.**

**Signature:**_____ **Date:**_____