****

**PATIENT INFORMATION**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

First Name Last Name Middle Initial

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Soc Sec #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ❐ M ❐ F Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Widowed**

**Preferred Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: ❐ Mobile ❐ Home ❐ Work**

**Secondary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you like appointment reminders? ❐ Email ❐ Text If text, who is your cell phone provider? \_\_\_\_\_\_\_\_\_\_**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who may we thank for referring you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Do you have a prescription from a provider for physical therapy? ❐ Yes ❐ No**

**If not, which doctor should we request a prescription from? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did your symptoms start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What location of your body is affected?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nature of condition: ❐ Automobile ❐ Work ❐ Other Are you currently receiving home health? ❐ Yes ❐ No**

**Have you had physical, occupational, speech, or chiropractic, in the last year? ❐ Yes ❐ No**

**What makes your symptoms better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes them worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate if you have had any of the following: Please mark any areas of your body that are affected:**

|  |  |
| --- | --- |
| ❐ Heart Problems  ❐ Diabetes  ❐ Lung Problems  ❐ Asthma  ❐ Dizziness  ❐ Stroke  ❐ Blood in Urine  ❐ Cancer  ❐ Seizures | ❐ High Blood Pressure  ❐ Shortness of breath  ❐ Chest Pain  ❐ Traumatic Head Injury  ❐ Hernia  ❐ Arthritis  ❐ Osteoporosis  ❐ Pacemaker  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medical/Surgical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PAYMENT INFORMATION**

*Please leave this section blank if you do not have insurance or if you do not wish to use it.*

Name of the person responsible for payment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? ❐Yes ❐ No Name of insurance company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you do not wish to use your health insurance for any reason, please notify the front desk coordinator**

Please note, we can only bill your personal insurance for therapy services (Not auto insurance or workers compensation companies). If you choose not to use health insurance, we will not be able to bill them retroactively.

**Authorization to pay:** I hereby authorize insurance (if I choose to use it) to directly pay Curnyn Physical Therapy for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

**Consent for care and treatmen**t: I hereby agree and give my consent to Curnyn Physical Therapy to provide appropriate rehabilitative care and treatment as considered necessary and in the best interest to attend to my physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds final judgement in such matters.

**Authorization to release patient information**: I hereby authorize Curnyn Physical Therapy to release any protected health information (PHI) required in the course of my examination or treatment to the insurance company or their affiliates of which I provided the information. I also authorize the release of appointment information left in a voicemail.

**HIPAA Consents**: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding scheduling and the billing of my account:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship Name/Relationship Name/Relationship

**Authorization to communicate electronically**: I understand authorized personnel (Including my physical therapist) from Curnyn Physical Therapy may communicate with me regarding scheduling/appointments, the treatment provided, home exercise programs, and educational content as it relates to my condition. I understand that my protected health information will not be communicated electronically. I understand I will have the opportunity to opt out of all future communications at any time using the “unsubscribe” option on the text or email.

My signature below certifies that I’ve read, understand, and fully agree to each statement in this document

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_