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?**_____

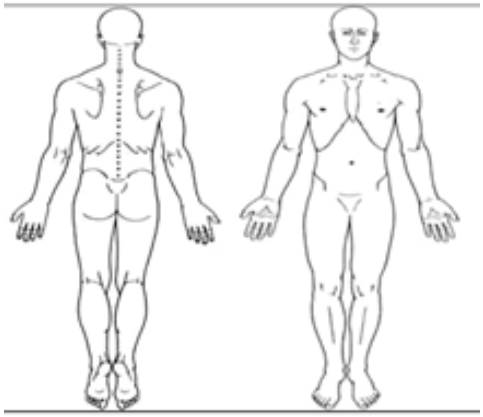
Nature of condition: ❒ **Automobile** ❒ **Work** ❒ **Other** **Are you currently receiving home health?** ❒ **Yes** ❒ **No**

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 ❒ High Blood Pressure
❒ Diabetes ❒ Shortness of breath
❒ Lung Problems ❒ Chest Pain
❒ Asthma ❒ Traumatic Head Injury
❒ Dizziness ❒ Hernia
❒ Stroke ❒ Arthritis
❒ Blood in Urine ❒ Osteoporosis
❒ Cancer ❒ Pacemaker
❒ Seizures Other:_____



Height:_____ **Weight:**_____

Current Medications:_____

_____

Medical/Surgical History:_____

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 treatment: 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: _____