



# Flowers Physical Therapy

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Care Physician/Family Doctor (s): \_\_\_\_\_  
Are you currently under the care of a Home Health Agency? No \_\_\_ Yes \_\_\_ if Yes, Name of Co: \_\_\_\_\_  
How did you hear about Neville Flowers P.T., P.C.? \_\_\_\_\_

## Insurance Information

Medicare #: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_  
Insurance Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policyholder's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ DOB #: \_\_\_\_\_

## **\*\*If Patient is a Minor\*\***

Responsible party for bill if other than patient: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Responsible party's address (if other than above): \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

## Consent to Release Medical Information:

I hereby authorize Neville Flowers P.T., P.C. to release any information acquired in connection with my therapy services including, but not limited to , diagnosis, clinical records, to myself, my insurance(s), physician(s) and \_\_\_\_\_.

## Consent to Obtain Medical Information:

I authorize Neville Flowers P.T., P.C. to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat Scans and MRI reports, along with Physician's Documentation.

## Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Neville Flowers P.T., P.C.

## Guarantee of Payment:

I agree to pay any charges that my insurance does not pay, I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician

Physician's Name: \_\_\_\_\_ Tel #: \_\_\_\_\_

Address: \_\_\_\_\_

Address City State ZC

Work: \_\_\_\_\_

Are you currently working? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many hours a week? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Please describe what you do at your job \_\_\_\_\_

Date of injury onset \_\_\_\_\_

Have you had any diagnostic test related to this problem? (i.e. MRI or X-Rays) Yes \_\_\_\_\_ No \_\_\_\_\_

Please Specify Where \_\_\_\_\_ When \_\_\_\_\_

Have you had any Physical Therapy in the past 12 months for this or any other problem Yes \_\_\_ No \_\_\_

If Yes Where \_\_\_\_\_ When \_\_\_\_\_

Have you had a related surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what was the date? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you have, or have you had, any of the following?

- Anemia
- Allergies
- Asthma
- Balance
- Back pain
- Bowel / Bladder Issues (incontinence)
- Cancer
- Chest pains
- Depression
- Diabetes
- Disc Problem
- Headaches
- Dizziness / Fainting
- Epilepsy
- Excessive Fatigue
- Fever, higher than 100 degrees F.
- Heart Attack
- Heart Disease
- High Blood Pressure
- Hypoglycemia
- Infectious Disease
- Knee pain
- Kidney Problems
- Liver / Gallbladder Problems
- Low Blood Pressure
- Low Exercise Level
- Metal Implants
- Nausea / Vomiting
- Neck pain
- Neck stiffness
- Open Wounds
- Osteoarthritis
- Osteoporosis
- Pacemaker or Defibrillator
- Perforated Ear Drums
- Radiation treatment within the last 3 months
- Rheumatoid Arthritis
- Ringing in Ears
- Seizures
- Shortness of Breath / Difficulty Breathing
- Skin Rashes
- Stomach or Intestinal Issues
- Stroke
- Thyroid Problems
- Tingling in Arms / Hands
- Tingling in Legs / Feet
- Typhoid / Cholera / Dysentery
- Vision Problem

Other Health Issues (please explain)

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Are you taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medications \_\_\_\_\_

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## INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical Therapy involves the use of many different types of physical evaluation and treatment.

At Neville A. Flowers P.T., P.C. we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercises you are performing and any specific risks associated with your exercises, your therapist will answer them.

**I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Name**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**NO FAULT**

Employee/Co: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZC: \_\_\_\_\_

Tel #: \_\_\_\_\_ ID #: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZC: \_\_\_\_\_

Tel #: \_\_\_\_\_ Date of Accident \_\_\_\_\_

Type of Accident: \_\_\_\_\_

Accident Claim #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZC: \_\_\_\_\_

Tel #: \_\_\_\_\_