The Therapy Institute LLC

PHYSICAL THERAPY SERVICES
Steve Houghton, PT, OCS, FAAOMPT
Chris Strickler, PT
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Nathan Rourke, PT, DPT
Collin Colegrove, PT, DPT
Cherie Gibbs, PTA

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI____ Preferred Name _____

DOB____/____/_____ SS #_____-_____-_____ Sex_____ Marital Status _____

Address _____

Address #2_____ City_____ State_____ Zip_____

Email: _____

Contact Information:

	Can we leave a message at number below
Home phone:	Y / N
Work phone:	Y / N
Cell Phone:	Y / N

Emergency Contact

Last Name_____ First Name_____ MI_____ Relationship_____

Phone_____

Employer

Name_____ Phone_____

Address_____

State_____ Zip_____

Problem

Problem Description_____ Date of Injury____/____/_____ Last Physician Visit____/____/_____

Referred By_____

Notes:_____

Did the injury happen at work? Y / N If yes, is this workers compensation?_____

Claim #_____ **Case Manager Name**_____ **Phone**___-____-_____

Was injury related to Auto Accident? Y / N **If yes, what state did it occur in:**_____

Policy #_____ **Case Manager/Adjuster Name**_____ **Phone**_____-_____-_____

Primary Insurance

Insurance_____ Primary Subscriber Name_____ DOB_____

ID_____ Group #_____ Relationship_____

Secondary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

Tertiary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____/_____/_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe relationship to patient:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION (Optional)

My protected health information may be disclosed to:

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that, as set forth in The Therapy Instiute, LLC Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Therapy Institute, LLC
1660 Haslett Rd, Ste 4
Haslett, MI 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization

With my signature below I agree to the following:

- I authorize release of information requested by my insurance plan for payment.
- I understand that verification of insurance benefits is done as a courtesy and not a guarantee of payment, coverage, or benefits stated by my insurance carrier.
- I understand that I am financially responsible for any balance not covered by my insurance carrier.
- A copy of this signature is as valid as the original.

_____ Date_____/_____/_____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient or Personal Representative Authority of Representative

Patient Name: _____ Date: _____

Medical History

Please list all of your relevant surgeries:

Please list any current medications you are taking:

Symptom Location

Please indicate on the body chart below where you are experiencing the symptoms that are bringing you into therapy TODAY. Previous symptoms and episodes will be reviewed by your therapist during your evaluation.