Health/History Information

Diagnosis and or Description of Problem: _____

Date of Onset: _____ **Claim#** (if applicable) _____

Physical Therapy is for the Treatment of (check one) Work Injury ☐ Auto Accident ☐ Other ☐

Previous serious illness, Injuries, Surgeries: _____

_____

Referring Physician Information

Referring Physician Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)-_____-_____ Fax: (_____)-_____-_____

Consent to Treat: ***The Information I have provided is current, accurate and true to the best of my knowledge. I understand by signing below I am giving The Woodlands Specialized Therapy & Rehab Services, PLLC permission and authority to care for me in accordance with the treatment plan as prescribed by my Therapist.***

Signature: _____ Date: _____

Privacy Policy: HIPAA Compliance: ***The privacy of your health information is important to us. By signing below you are acknowledging receipt of the "Notice of Privacy Policies". Please review carefully.***

Assignment of Benefits: ***I authorize payment directly to The Woodlands Specialized Therapy and Rehab Services, PLLC for services I receive.***

Payment Guarantee: ***In consideration of the services rendered and to be rendered to the above named patient by The woodlands Specialized Therapy and Rehab Services, PLLC I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company.***

Consent to Release Information: ***I give permission to The Woodlands Specialized Therapy and Rehab Services, PLLC to release information to my insurance company, attorney, assignees and/or beneficiaries.***

I understand by signing below I agree to all of the above including the Notice of Privacy Policies Acknowledgement, Assignment of Benefits, Payment Guarantee and Consent to Release Information.

Signature: _____ Date: _____