## Health/History Information Diagnosis and or Description of Problem: \_\_\_Claim# (if applicable) \_\_\_\_ Date of Onset: 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: \_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_ Fax: ( \_\_\_\_\_\_-\_--\_--\_-Phone: ( \_\_\_\_\_\_-\_\_\_-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. 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. Date: Signature: \_\_\_