SportsCare Physical Therapy & Armworks Hand Therapy

WELCOME TO OUR PHYSICAL THERAPY OFFICE. If you have any questions regarding your therapy, please feel free to ask. We are here to assist you in returning to good health. We are not affiliated with your physician and do not obtain your insurance information from them. These forms must be completed for insurance and record keeping purposes.

Patient Information

Name: _____ Date of birth:_____ Age: _____

Social Security Number: _____ Sex: ☐ Female ☐ Male

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Home: (____)_____ Cell: (____)_____

Please select how you would like to receive appointment notifications: ☐ Email ☐ Phone Call ☐ Text Message

Date of symptom onset, injury or surgery: _____ ☐ Work ☐ Auto Accident ☐ Sports Related ☐ Other: _____

Name of person who referred you (Physician, Friend, Coach, Etc.): _____

Primary Care Doctor/Clinic: _____ Phone: (____)_____

In case of emergency contact: _____ Relationship: _____ Phone: (____)_____

Attorney Information

Do you have an attorney representing you for your current condition? ☐ Yes ☐ No

Attorney's Name: _____

Address: _____ Phone: (_____)_____

Personal Information Release

Other than your insurance, doctor, or attorney, list person(s) allowed to receive your personal medical information:

Name: _____ Relationship: _____ Phone: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____

I _____authorizes direct payment of benefits to SportsCare Physical Therapy and permits the release of all information necessary to process my claim. If the patient is a minor, I certify that I am the parent or legal guardian and consent to treatment. I acknowledge that failure to attend or provide at least 24 hours' notice for cancellations or rescheduling may impact the clinic's ability to provide care. I hereby consent to evaluation and treatment by SportsCare Physical Therapy and authorize the provision of services deemed medically necessary and appropriate for my condition. I understand that rehabilitation services may involve bodily contact, including contact with sensitive areas, as clinically appropriate.

Signature: _____ Date: _____

I have read and agree to the terms stated on the Notice of Privacy Practices form. A paper copy was offered and provided to me if requested in office during time of visit

Signature: _____ Date: _____

I have read and agree to the terms stated on the Notice and Agreement form. A paper copy was offered and provided to me if requested in office during time of visit.

Signature: _____ Date: _____