Physical Therapy Services
Medical History Form

Last Name _____ First Name _____ DOB _____ Age _____

Diagnosis: _____

Physician: _____

Check Yes or No. If yes, please explain in the space provided.		
☐ Yes	☐ No	Are you pregnant? _____
☐ Yes	☐ No	Currently being treated elsewhere for this or another injury?_____
☐ Yes	☐ No	History of high or low blood pressure? _____
☐ Yes	☐ No	History of heart disease? Heart attacks/M.I? _____
☐ Yes	☐ No	Presently have a pacemaker? _____
☐ Yes	☐ No	Previous strokes/CVA? _____
☐ Yes	☐ No	History of any illness (i.e., diabetes, asthma, seizures, etc.)?_____
☐ Yes	☐ No	Current/history of any skin diseases?_____
☐ Yes	☐ No	Any emotional/psychological disturbances? _____
☐ Yes	☐ No	Please list current medications. _____
☐ Yes	☐ No	Any allergies?_____
☐ Yes	☐ No	Respiratory difficulties? _____
☐ Yes	☐ No	Any bowel or bladder disturbances? _____
☐ Yes	☐ No	Any unusual bleeding?_____
☐ Yes	☐ No	Any unusual reactions to heat or cold?_____
☐ Yes	☐ No	Special diet restriction? _____
☐ Yes	☐ No	Any present visual problems? _____
☐ Yes	☐ No	Any present hearing problems (including hearing aids)?_____
☐ Yes	☐ No	Do you smoke? How many packs a day? _____
☐ Yes	☐ No	Is visit accident related? Work? Auto? Other?_____
☐ Yes	☐ No	History of fractures? Dislocations? _____
☐ Yes	☐ No	Arthritis or joint problems? _____
☐ Yes	☐ No	Sensory disturbances? _____
☐ Yes	☐ No	Any current movement/tasks unable to perform?_____
☐ Yes	☐ No	Do you require any special help at home? _____
☐ Yes	☐ No	Previous hospitalizations/surgeries/cancer? _____
☐ Yes	☐ No	Please list recreational activities (including prior to visit). _____
☐ Yes	☐ No	Do you have any other form of health insurance coverage? If yes, please print the name of the insurance policy:_____

I, the undersigned, do hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as other data pertinent to my treatment to the physician who referred me for therapy, and/or to any organization or person responsible for the payment of my account. A copy of this can be considered as an original for insurance purposes and valid as an original.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Physical Therapy Services to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition. I, the undersigned, will allow Physical Therapy Services to receive/send medical records pertaining to my condition via fax machine and/or mail. **I HAVE READ AND UNDERSTAND THE ABOVE POLICIES**.

X_____ X _____

Patient or Guardian's Signature Date Therapist's Signature Date

UPDATED 2/24/2015

physical therapy services

"Relief Lies Within"

PATIENT INFORMATION	LAST NAME FIRST M.I.	PHONE NO.	CELL PHONE NO.	E-mail	
	STREET ADDRESS	CITY STATE ZIP			
	SOCIAL SECURITY NO.	BIRTHDATE AGE	OCCUPATION	EMPLOYER'S NAME PHONE NO.	
	EMPLOYER'S STREET ADDRESS	CITY STATE ZIP			
	REFERRING PHYSICIAN	PRIMARY PHYSICIAN	HEIGHT	WEIGHT	
EMERGENCY CONTACT	NAME OF PERSON TO NOTIFY	RELATIONSHIP TO PATIENT	HOME PHONE	WORK PHONE	
	STREET ADDRESS	CITY STATE ZIP			

"I understand in the event I default on my balance, my account will be charged for all and any collection fees, attorney fees and court costs. I understand these fees will be my responsibility."

$30.00 cancellation fee will be assessed for appointments canceled without 24 hour notice.
$50.00 cancellation fee will be assessed for 5pm and 6pm appointments canceled without 24 hour notice.

ESTIMATE

	Calendar Year Deductible for Primary	**Met**
	% Co-insurance	
	Co-payment for Visit	

Please note: *Estimate amounts may change as the therapist updates your rehabilitation program.*
I choose to have my insurance company assign benefits to your office. I understand that any portion of the estimate amount not paid by my insurance company and claims not paid within 60 days will be my responsibility and I will pay the balance. I hereby assign benefits to your physical therapy office.

_____ _____

Patient Signature Date

Thank you for choosing Physical Therapy Services.

UPDATE 03/26/2015

Penemarie K. Murphy, Inc dba Physical Therapy Services

ASSIGNMENT OF BENEFITS and MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Penemarie K. Murphy, Inc dba Physical Therapy Services, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said Penemarie K. Murphy, Inc. dba Physical Therapy Services, which checks, drafts, or money orders are made payable for services which have been made by Penemarie K. Murphy, Inc dba Physical Therapy Services , at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Penemarie K. Murphy, Inc dba Physical Therapy Services or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said Penemarie K. Murphy, Inc dba Physical Therapy Services as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Penemarie K. Murphy, Inc dba Physical Therapy Services or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____Hereby authorize_____
(Name of Insured/Patient) (Name of Insurance Company)

to make medical benefit payments otherwise payable to me for services rendered by Penemarie K. Murphy, Inc dba Physical Therapy Services, but not to exceed the charges of those services, payable to and mailed directly to:

Penemarie K. Murphy, Inc dba Physical Therapy Services
P O Box 11677
Jacksonville, FL 32239

Furthermore, I hereby IRREVICABLY Assign to Penemarie K. Murphy, Inc dba Physical Therapy Services the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and/or charges provided by Penemarie K. Murphy, Inc dba Physical Therapy Services.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this_____day of _____20____.

_____ _____
PATIENTS SIGNATURE PATIENT'S NAME (Please Print)

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Physical Therapy Services or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-today health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected information may be used or disclosed. You may review the prior notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Physical Therapy Services may or may not agree to restrict the use or disclosure of your protected health information.

If Physical Therapy Services agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Physical Therapy Services reserves the right to modify the private practices outlined in the notice.

Acknowledgment and Signature
I hereby acknowledge I have received and had and opportunity to ask question concerning the above named practice's Notice of Privacy Practices.

_____
Signature Date

Signature
I have reviewed this consent form and give my permission to Physical Therapy Services to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship to Patient

☐ 7001 Merrill Rd • 32277 • (904) 744-0277

☐ 12740-2 Atlantic Blvd • 32225 • (904) 220-8311

UPDATED 01/29/2015