PATIENT INFORMATION & CONSENT

CBPT
Sports and Orthopedic Physical Therapy

General Information:

Patient Name: _____ *Date of Birth:* _____
Address: _____ *Email:* _____
_____ *Gender:* _____
Home Phone: _____ *Cell Phone:* _____ *Marital Status:* _____
Guarantor: _____ *Guarantor Relationship:* _____
Primary Care Physician: _____ *How were you referred to our clinic?:* _____

Employer Information:

Employment Status: _____ *Employer:* _____ *Employer Phone:* _____

Emergency Information:

Emergency Contact: _____ *Phone Number:* _____
Relationship to Patient: _____

Injury Information:

Date of Injury: _____ *Employment Related: YES / NO* *Auto Related: YES / NO* *Other Injury:* _____

Attorney Information:

Legal Case Pending?: YES / NO *Attorney Name:* _____ *Phone Number:* _____

Have you received Physical, Occupational or Speech Therapy in the last 180 days? *YES / NO*

Consent for Care & Treatment:

I agree and consent to receive services according to the applicable standards of care used for evaluating or treating my medical condition. In the event of an unexpected emergency, the therapy staff will initiate basic life support measures. The Fire Rescue Department will be called to provide additional support measures and to transfer the patient to an Emergency Room if indicated. The patient's referring physician will be notified to any emergencies that may arise. In addition, I hereby release Coltman & Baughman Physical Therapy, PA of any responsibility for my personal property, which I choose to bring to therapy.

Consent for Release of Information:

I understand that my health information is confidential but may be used or released in accordance with Federal & State laws for purposes of treatment, payment, or healthcare operations; such as for outcomes assessment, quality assurance, business planning/improvement activities, service providers on my evaluation and/or treatment team, other treating healthcare providers involved in my care and utilization review organizations or agencies that provide managed care services for my insurance benefits. I know and agree that my health information may be disclosed to worker's compensation agencies, insurance companies, or employers for purposes of worker's compensation and worksite safety laws. I authorize Coltman & Baughman Physical Therapy, PA to furnish my health or medical information to my treating physician(s), insurance carrier(s), and other payers as necessary to process claims and obtain reimbursement or payment. In addition, I direct my insurance carrier(s) and other payers to accept a photocopy of this assignment in lieu of the original. I assume all responsibility for the confidentiality of medical record documentation released directly to me by Coltman & Baughman Physical Therapy, PA as the patient or legal guardian of the patient. I understand that medical record documentation after release is no longer protected by Federal & State Privacy Regulations.

In addition, I authorize Coltman & Baughman Physical Therapy, PA to discuss billing, treatment, and medical conditions with the following friends, family, or others involved in my care: _____. I understand that this consent does not authorize Coltman & Baughman Physical Therapy, PA to release copies of medical records to the people listed above, without written consent. I understand that I can revoke this consent by sending a written letter to: Coltman & Baughman Physical Therapy at 350 13th Ave. S. Jacksonville Beach, FL 32250.

Missed Appointments:

When you miss an appointment specifically reserved for you, other patients in need of medical care cannot be seen. We ask that you give us a 24-hour notice if it becomes necessary to change an appointment. After 3 consecutive missed visits, we reserve the right to remove any remaining scheduled appointments.

Acknowledgements:

By signing below, I agree that I have received a copy of the Notice of Privacy Practices from Coltman & Baughman Physical Therapy, P.A.

I acknowledge that the information above is accurate to the best of my knowledge and that all of my medical insurance information has been presented.

Patient Signature: _____ *Date:* _____

CBPT Staff Signature: _____ *Date:* _____