Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Sea Coast Physical Therapy Inc...

I understand that I will be receiving an initial evaluation followed by one or several treatment sessions. These sessions may include one or more of the following: Joint mobilization or manipulation; soft tissue work; manual therapy; electrical stimulation; ultrasound; Heat/ice; mechanical and manual traction; passive/active range of motion; strengthening; stretching; exercise; and/or activity of daily living modification.

Patient or Guardian signature with date: ________________________________

Assignment of Benefits and Insurance Proceeds

I hereby authorize payment from my insurance company of medical benefits for services rendered to Sea Coast Physical Therapy Inc. by an assignment of benefits. The completion of insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for Physical Therapy.

Signature with date: ________________________________

Release of Information

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician/s. I permit a copy of this authorization to be used in place of the original.

Signature with date: ________________________________

Receipt of Privacy Practice

I have received a copy of Sea Coast Physical Therapy notice of Privacy Practices and have had an opportunity to ask questions.

Signature with date: ________________________________
Patient Intake Form

Name_________________________________ SS#__________________________

Date of Birth_________________________ Gender _______ Marital Status _______ Home Phone #__________________

Work Phone #_________________________ Cell #_________________________ Pager________ Email_____________________

Home Address__________________________

City_________________________________ State_______________ Zip____________________

Employer______________________________

Address________________________________________

City_________________________________ State_______________ Zip____________________

Spouse’s Name__________________________ Wk #__________________

Emergency Contact______________________ Phone #__________________

Whom May We Thank for Referring You to us?________________________________________

Primary Care Physician______________________ Phone #__________________

**Please fill out if Spouse or Other is Primary Insured on Insurance Card**

Their Name________________________________ Relationship to you ________________

SS#__________________________ Date of Birth _____________ Phone#__________________

**Please Fill Out if Workers Compensation Case**

Name of WC Carrier_________________________________ Phone#__________________

Address__________________________________________

City_________________________________ State_______________ Zip____________________

Claim #________________________________ Name of adjustor________________________

**Please Fill out if treatment is covered by Auto Insurance**

Claim #________________________________ Name of adjustor________________________

Phone #__________________________________________

**Who Will Be Responsible For This Bill?**

__________________________________________

7979 Market St               98 Quarter Horse Ln.
Wilmington, NC  28411        Hampstead, NC 28443
910-686-6845 Phone          910-270-6488 Phone
910-686-6837 Fax            910-270-6489 Fax
Past Medical History Form

Name: ___________________________________________ Date: ___________ Age: ___________

Occupation: ____________________________________________________________

Type of work: Example: Lifting, Bending, standing, sitting: __________________________

Past Medical History:
Do you have any previous history of: Yes or No

High Blood Pressure___________ Pacemaker______________

Heart Conditions_______________ Seizures_______________

Stroke(s)________________________ Cancer_____________________

Diabetes________________________ Allergies___________________

Other____________________________

Have you been admitted to the hospital or undergone any surgical procedures in the past 5 years?____ If so please list: ____________________________________________

Have you received any physical therapy treatment in the past 5 years?__ If yes, for what condition and was the treatment effective? ____________________________________________

Have you had any other previous medical problems or surgeries?_ If yes, please list: __________

Did you receive any diagnostic tests (radiographs, MRI, CAT scan) for today’s problem?__ If yes, please list: ____________________________

What medications are you currently taking?_____________________________________

Are you pregnant?______________

Name of your primary doctor:_________________________________________________

Name of your Orthopedic Doctor:_____________________________________________

Patient Signature________________________________________ Date: ___________

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