

PHYSICAL THERAPY SPECIALISTS CLINIC, INC.

MEDICAL QUESTIONNAIRE

Name _____ Date _____

List any known allergies _____

Known side effects (swelling, skin rash, etc.) _____

List any secondary MEDICAL COMPLICATIONS that you may have (heart murmur, diabetes, insulin shock, pacemaker, etc.) _____

Family Doctor _____ Phone () _____

Friend/Relative OUT OF HOUSEHOLD: _____ Phone _____

CONSENT FOR TREATMENT

THE FOLLOWING CONDITIONS ARE ARGREED TO:

I hereby authorize Physical Therapy Specialists Clinic, Inc. to provide professional services, which may include physical, speech, occupational therapy, sports medicine services, or other services which may be prescribed by my physician. I understand all services are provided at the direction of and in consultation with a licensed physician. I further understand I may choose to terminate these services by notifying my physician and/or Physical Therapy Specialists Clinic, Inc. I authorize the release of any information necessary for Physical Therapy Specialists Clinic, Inc. to receive payment for the services with which am to be provided. I have been given a copy of PTSC, Inc. Notice of Privacy Practices. I understand that I have the right to choose to read or not to read the Notice of Privacy Practices before signing this Consent for Treatment. I understand that upon reading the Notice of Privacy Practices set for by PTSC, Inc. if I have any questions or concerns that I may contact a member of the HIPAA (Privacy) Committee (employee of PTSC) to answer any of my questions or concerns. It is the policy of Physical Therapy Specialists Clinic, Inc. to treat and make all services available to all persons without regard to race, sex, age, handicap, or national origin. There is no distinction in eligibility for or manner of providing patient services.

I further understand that my treatment will be in an open treatment environment with other patients which may result in other patients, other patient's family members or individuals involved in their care, as well as other staff overhearing conversations between me and my therapist in regards to my health information.

By signing this questionnaire, I authorize Physical Therapy Specialists Clinic, Inc. to treat my condition as ordered by physician, administer medications necessary for proper treatment, and understand the above practices of Physical Therapy Specialists Clinic, Inc.

Signature _____ Date _____

If other than patient, state relationship _____

Witness Signature _____ Date _____