S F R
STRENGTH • FITNESS • RECOVERY
PHYSICAL THERAPY

Patient History Form

Personal Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____ City, State, Zip Code: _____

Phone Number: _____ Email Address: _____

Emergency Contact Information:

Emergency Contact Name: _____ Phone #: _____

Relationship: _____

Primary Physician Information:

Physician's Name: _____

Insurance Information:

Insurance Provider: _____ Insurance ID Number: _____

Auto case Injury or Workers compensation case? If yes, please specify:

_____

Medical History:

Please check all that apply or provide additional details as necessary.

1. Body Part: _____

2. Do you have any current medical conditions? If yes, please specify:

_____

3. Have you had any surgeries or significant injuries in the past? If yes, please provide details:

_____

4. Any known results of recent radiographs, MRI, CT, PET or other tests?

_____

5. Do you have any known allergies? If yes, please specify/inform our staff:

_____

6. Are you currently taking any medications? If yes, please specify/inform our staff:

_____

7. Have you previously received physical therapy **IN THE LAST 3 MONTHS**? If yes, please specify/inform our staff:

_____

8. How would you rate your current pain? None 0 1 2 3 4 5 6 7 8 9 10 Emergency Room

10. Is there any other information or medical history that you believe is important for us to know?

_____ _____

Check all that apply

- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Heart Disease
- ☐ Blood Disorders
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Metal Implants
- ☐ Respiratory Problems
- ☐ Osteoporosis
- ☐ Are you pregnant?
- ☐ Smoker

Consent and Authorization Form

Please initial next to each line.

_____ **Consent and Signature:**
I certify the above information is accurate and understand it will be used for my physical therapy treatment.

_____ **Release of Medical Information:**
I authorize South Florida Rehab & Training Center to release my medical information to my insurance provider, healthcare providers, and necessary third parties for claims processing, payment, and treatment coordination.

_____ **Media Release:**
I permit South Florida Rehab & Training Center to use photos, videos, and media of me (or my child) for promotional purposes.

_____ **Consent to Treat Minor:**
I, [Parent/Guardian Name], authorize South Florida Rehab to seek necessary medical treatment for my child during physical therapy sessions and understand I am responsible for medical expenses.

_____ **Assignment of Benefits/Consent to Treatment:**
I assign insurance benefits to South Florida Rehab & Training Center and consent to treatment for one body part at a time. I understand I am responsible for charges not covered by insurance.

_____ **Credit Card Authorization:**
I authorize charges to my credit card for amounts I am responsible for, with receipts available upon request. Non-payment will result in collection actions.

Policies

- **Scheduling & Appointments:** Schedule at least 3 days in advance. Insurance covers one body part at a time. Additional charges may apply for extra modalities. Copayment/coinsurance is due at the time of the appointment.
- **Cancellations & No-Show:** $25 fee for cancellations/no-shows without 24-hour notice. Reminder texts are a courtesy.
- **Products & Packages:** Non-refundable. Refunds (if approved) processed after discharge. Packages expire 60 days from purchase.
- **Parking:** Parking available in front of SFR and a lot next to Pinch a Penny.
- **Partnership with Schools:** We partner with schools, educational programs, and research centers. Students may be present during your visit.

Patient's Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access it.

Please review it carefully.

Legal Duty
We are required by law to protect your health information and follow the practices outlined in this notice. We may change our privacy practices and update this notice as needed. Changes will apply to all health information we maintain.

Uses and Disclosures of Health Information
We may use and disclose your health information for treatment, payment, and healthcare operations.

- Your information will only be shared with your written consent, except in emergencies or as required by law.
- We will assist with insurance claims and related matters upon your request, and will only release information with your signed consent.
- We may share your information with other healthcare providers or agencies with your consent.

You have the right to revoke your consent at any time, though it will not affect actions we took before the revocation.

Contact Information
For copies of this notice or more information, please contact:
South Florida Rehab & Training Center Inc.
(305) 905-4188
info@southflcenters.com

Acknowledgment
By signing below, you acknowledge receiving this Notice of Privacy Practices and consent to the use of your health information as described.

Patient's Signature: _____ Date: _____

Please complete this form and bring it with you to your initial appointment. If you have any changes to your medical history in the future, please inform our staff. Thank you for providing us with the necessary information to better serve you during your physical therapy treatment.