SEA COAST
PHYSICAL THERAPY

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
Wilmington, NC 28411
910-686-6845 Phone
910-686-6837 Fax

98 Quarter Horse Ln.
Hampstead, NC 28443
910-270-6488 Phone
910-270-6489 Fax

SEA COAST
PHYSICAL THERAPY

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:_____

7979 Market St
Wilmington, NC 28411
910-686-6845 Phone
910-686-6837 Fax

98 Quarter Horse Ln.
Hampstead, NC 28443
910-270-6488 Phone
910-270-6489 Fax