SportsCare Physical Therapy & Armworks Hand Therapy

WELCOME TO OUR THERAPY OFFICE. If you have any questions regarding your therapy, please feel free to ask. We are here to assist you in returning to good health. We are not affiliated with your physician and do not obtain your insurance information from them. These forms must be completed for insurance and record keeping purposes.

Patient Information

Name: ____ Date of birth: ________________ Age: ____

Social Security Number: ________________________ Sex: □ Female □ Male

Address: ____ City: _____________ State: ____ Zip Code: __________

Email: _____________________________________ Home: (____) _______________ Cell: (____) _______________

Please select how you would like to receive appointment notifications: □ Email □ Phone Call □Text Message

Date of symptom onset, injury or surgery: __________ □ Work □ Auto Accident □ Sports Related □ Other: ________

Name of person who referred you (Physician, Friend, Coach, Etc.): ____

Primary Care Doctor/Clinic: ____ Phone: (____) _______________

In case of emergency contact: _____________________ Relationship: ____________ Phone: (____) ______________

Insurance Information

□ Private □ Motor Vehicle Accident □ Workers Compensation Insurance Name: ___________________________

Attorney Information

Do you have an attorney representing you for your current condition? □ Yes □ No

Attorney's Name: ____

Address: ____ Phone: (____) _______________

Personal Information Release

Other than your insurance, doctor, or attorney, list person(s) allowed to receive your personal medical information:

Name: _______________________________________ Relationship: ___________ Phone: (____) _______________

Name: _______________________________________ Relationship: ___________ Phone: (____) _______________

I ________________________________ authorize my insurance company to make payment directly to SportsCare and/or Armworks. I give SportsCare and/or Armworks permission to send all necessary information about my claim and injury to my insurance company. As Parent/Guardian, I authorize SportsCare and/or Armworks to treat my minor child.

Failure to show and late-cancelled appointments jeopardize the ability of SportsCare Physical Therapy and Armworks Hand Therapy to provide appropriate care to the needs of patients. Please give 24 hours of notice prior to cancelling or rescheduling an appointment.

Signature: ____ Date: _________________

I have read and agree to the terms stated on the Notice of Privacy Practices form. A paper copy was offered and provided to me if requested in office during time of visit.

Signature: ____ Date: _________________

I have read and agree to the terms stated on the Notice and Agreement form. A paper copy was offered and provided to me if requested in office during time of visit.

Signature: ____ Date: _________________