BACKtoGOLF PERFORMANCE & FITNESS

NAME_______________________________________ DATE OF BIRTH___________________________

PHONE #___________________ CELL#___________________ SOCIAL SECURITY #______________________

(REQUIRED FOR WORK COMP)

MAILING ADDRESS ______________________________ ________________ ________ ____________

Street or PO Box | City | State | Zip

REFERRING MD ______________________ OCCUPATION_________________ POSITION______________

Please describe your current complaint or limitation: ____

When did the condition begin? ____

What is your goal for physical therapy? ____

Please describe the nature of your pain & indicate on the picture the location of your symptoms (*select all that apply*):

[ ] Sharp Pain [ ]Dull Pain [ ]Throbbing [ ]Shooting

[ ] Burning [ ]Tingling [ ]Numbness [ ] Tender

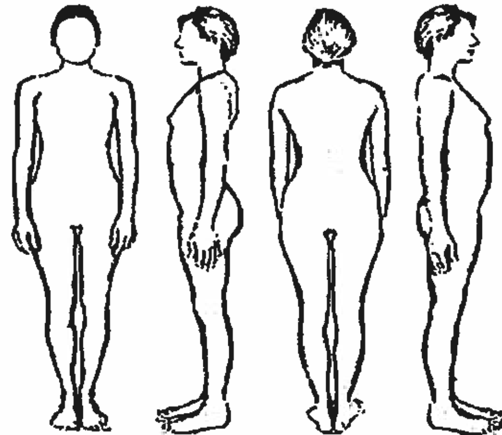
[ ]Constant [ ]Frequent [ ] Occasional [ ] Intermittent

Intensity of pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Intensity of pain with movement: 0 1 2 3 4 5 6 7 8 9 10

What causes pain to increase? ______________________

Date of Surgery (if applicable) ______________________



Activity Level (Circle One): LOW/SEDENTARY MEDIUM HIGH ATHLETE/SPORTS_______________

Please check all boxes that apply:

PAST	PRESENT		PAST	PRESENT	
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Angina
[ ]	[ ]	Heart Attack	[ ]	[ ]	Stroke
[ ]	[ ]	Asthma	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Tumor	[ ]	[ ]	Cancer (Location:_______________)
[ ]	[ ]	Systemic Lupus	[ ]	[ ]	Hepatitis
[ ]	[ ]	Epilepsy	[ ]	[ ]	Diabetes
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Pregnancy
[ ]	[ ]	Drug/Alcohol Dependence	[ ]	[ ]	Tobacco/Smoking
[ ]	[ ]	Other ____________________			

Current Medications: ____

Hospitalization/Surgical Procedures: ____

X_________________________ X_________________________ _____/_____/_____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**

BACKtoGOLF PERFORMANCE & FITNESS

CREDIT CARD ON FILE FORM

REQUIRED FOR PRIVATE PAY PATIENTS – WITHOUT INSURANCE

We have implemented a policy which enables you to maintain your credit card information securely on file with BACKtoGOLF Physical Therapy. In providing us with your credit card information, you are giving BACKtoGOLF permission to automatically charge your credit card on file for your co-pay/due balance **at time of service**. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Name on Card: ______________________________

Card Number: ______________________________

Expiration Date: ____________ **CCV #** ____________ **Zip Code:** ____________

Receipts?: YES / NO Email OR Text (Please provide email or phone #) ____________________

BILLING ADDRESS (If different than one on file – **IF SAME** LEAVE BLANK):

______________________ ______________ ________ ________

STREET CITY STATE ZIP

By signing below, I authorize BACKtoGOLF to charge co-pays and outstanding balances on my account to the above Credit Card.

X______________________________ ____________________

Authorizing Cardholders Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

BACKtoGOLF PERFORMANCE & FITNESS

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of you *Notice of Privacy Practices*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

PLEASE ASK OUR FRONT DESK IF YOU WOULD LIKE TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I have reviewed the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT above and am signing below to verify that all of my questions have been answered and that I understand all policies as stated above.

X____________________ X____________________________ _____/_____/_____

Patient Signature Guardian Signature **(if patient is <18 years old)** **Date**