THERAPY WORKS

PATIENT INTAKE INFORMATION Today's Date:_____

First Name M.I. Last Name	Birthdate Age	Sex M/F	Marital Status S / M / D / W	SS# *(Work Comp Required)*

Street Address	City State Zip Code

Employed or Student	Current Employer / Address and Phone *(Required for Worker's Compensation)*

Email Address	Would you like to receive appointment reminders by email? ☐ Yes, notify by email ☐ No, do not Please check if you do not wish to be a part of our monthly newsletter or mailing list ☐ No

Home Phone ( )	Work Phone ( )	Other Phone ( )	Driver's Lic # *(Please provide copy for our records)*

Cell Phone ( )	Would you like to receive appointment reminders by text? ☐ Yes, notify by text ☐ No, do not

Primary Person to Contact in Case of an Emergency	Relationship	Home Phone ( )	Work/Cell Phone ( )

Referring Physician	Office Address	Phone ( )	Fax ( )

Area of body to be treated? Date of injury/onset of pain? / /

Do you give your permission to discuss your medical condition with another person and/or authorize to have someone present in the treatment room? ☐ Yes ☐ No If yes, please give name and relationship:

Pursuant to Privacy Rule section 164.522 (b) Do you give permission for TherapyWorks' staff to communicate and leave messages on your answering machine? Y/N Cell Phone? Y/N Email? Y/N Text? Y/N

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical medicine is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for (3) three consecutive appointments, Therapyworks has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Therapyworks requires 24-hour advance notice of cancellation. If I fail to give a 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 charge (which is not covered by insurance).

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for TherapyWorks of Jacksonville,Inc. to furnish medical care and treatment considered necessary and proper in assessing and treating my physical condition. This consent is intended as a waiver of liability for such treatment with exceptions of acts of negligence. I, the undersigned, will allow Therapy-Works of Jacksonville, Inc. to receive/send/medical records pertaining to my condition via fax/mail/email with physi-cian's and insurance companies as required. If I am being seen for non-prescribed massage therapy, I will inform the therapist of any and all medical illness/diseases that may be contraindicated to the practice of massage therapy.

PRIVACY PRACTICE NOTIFICATION

I have been notified and have read TherapyWorks' HIPPA privacy practices information that is posted in reception area.

Signature:_____Date:_____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient ◯ **MOTHER** ◯ **FATHER** ◯ **GUARDIAN** ◯ **SELF**

All Information on this form is confidential.