



Thank you for choosing Physical Therapy for Women!

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Date _____

Patient Name: _____ Nickname: _____
(First) (Middle) (Last)

Date of Birth: _____ Height: _____ Weight: _____

Address: _____
(Street)

(City) (State) (Zip code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Emergency Contact: _____
(Name) (Phone #)

Relationship to patient: _____

Which is your primary phone? _____

Would you like to receive appointment reminders? _____

If yes, by text, voice or email _____ * Note that PTFW does not encrypt emails

Work Status: (circle one) Full time Part time Student Retired Disability Unemployed

Marital Status: (circle one) Married Single Widowed Other

Would you like to be added to our email list to receive our Monthly Newsletter? _____

Referring Physician: _____ Return to Dr. Date: _____

Reason for PT evaluation: _____ Date of first symptom _____

Primary Insurance _____ Secondary Insurance _____

IMPORTANT: If you are currently receiving home health care, physical therapy, or chiropractic care, or have received physical therapy for any diagnosis this year, please let us know. This may affect your insurance coverage.

Please Check and sign below:

I am not currently receiving home health care, physical therapy, occupational therapy, speech therapy or chiropractic care for any other diagnosis.

****From the list above which type of care are you currently receiving?

I have read and understand the financial policy given to me by *Physical Therapy for Women, Inc.*

I have read and understand the HIPAA Form.

MEDICARE PATIENTS - Have you received physical therapy this year? If YES – How many visits did you attend? _____

I agree that the above information is correct to the best of my knowledge.

Patient Signature/Date

IMPORTANT: Only sign below if you check yes for any of the following:

I would like a copy of *Physical Therapy for Women, Inc's* Financial Policy and/or the HIPAA Form.

I authorize Physical Therapy for Women, Inc. to use my photographic image in marketing materials advertising our services that will be viewed by the general public. This includes PTFW's website, FaceBook page, and printed marketing materials.

I have completed the Credit Card Authorization form and I authorize *Physical Therapy for Women, Inc* to charge my credit card for agreed upon copayments/coinsurances. I understand that my information will be saved to file for future transactions on my account. I can cancel authorization at anytime by contacting the *Physical Therapy for Women, Inc* billing department

I have read and agree with the above statement.

Signature / Date

_____ / _____