BALANCED BODY
PHYSICAL THERAPY

Patient's Name_____

Date of Birth _____ **Age** _____

Address _____

City _____ **Zip Code** _____

Phone Number_____

Email Address _____

How did you hear about us? _____

Primary Complaint _____

Secondary Complaint _____

Are you pregnant or nursing? _____

Please list dates and types of surgeries. _____

_____

_____

_____

If you have/had any of the following, please provide detail. High blood pressure, heart disorder/disease, high cholesterol, lung disorder/disease, depression, chronic fatigue, pacemaker, allergies to lotions, arthritis, circulation disorders, dizzy spells, latex allergies, seizures, chronic pain, cancer, osteoporosis.

_____

_____

_____

_____

_____

_____

Other relevant medical information: _____

_____

Balanced Body Physical Therapy, LLC
401-580-4846
balancedbodyfl@gmail.com

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Consent for Treatment

- I hereby consent to the administration of appropriate therapeutic treatment/procedures as requested by the patient and/or physician prescribing care.
- I hereby consent to the treatment necessary for the care of the patient.
- I hereby agree not to hold Balanced Body Physical Therapy, LLC or any of its owners liable for any injury that may be sustained during or after any treatment session.

Financial Responsibility

- I understand that the payment of charges is due in full at the time of service.
- I acknowledge that I am the responsible party for all financial charges.
- I understand that Balanced Body Physical Therapy kindly requests a minimum of 24 hours notice for cancelled appointments.

Release of Medical Information

- I acknowledge that I allow fax and secure email transmittal of medical records as necessary and as authorized at my discretion.
- I acknowledge that Balanced Body Physical Therapy, LLC will comply with all HIPAA and informational privacy laws and will practice due diligence in protecting my information.

Patient Signature _____Date _____

If the patient is under 18 years of age, a parent or guardian must sign below.

_____

Printed Name | Signature | Relationship to Patient | Date