HULSEY THERAPY SERVICES
Rehab & Sports Medicine

PATIENT INFORMATION and CONSENT FORM

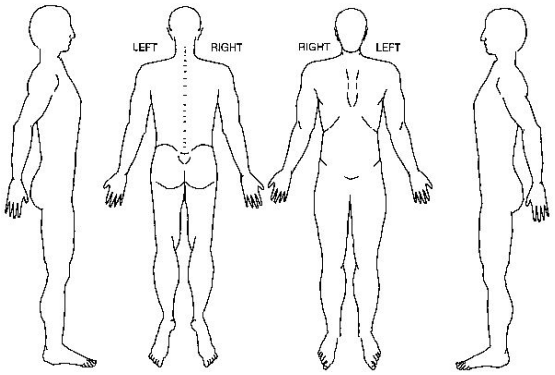
PATIENT

First Name : _____ MI ____ Last : _____ DOB : _____AGE : _____

SS # : _____ Phone Number : _____ Emergency Contact/Phone : _____

PAIN

Please mark the areas on the drawing below where you feel discomfort or pain



RATE YOUR OVER-ALL DISCOMFORT ON THIS 0 –TO- 10 SCALE

1 2 3 4 5 6 7 8 9 10

ONSET

Date of Injury –or- Onset of Symptoms : _____ Have you had surgery : NO YES : Date _____

How Were You Injured : _____ Is this Workers Comp : NO YES

Chief Complaint :_____

Prior Treatment for this condition : NO YES _____ Where : _____ When : _____

MEDICAL HISTORY

Circle if you have any of the following

Diabetes	Blood Pressure Problems	Pace Maker/Defibrillator	Currently Pregnant : No Yes
Kidney Problems	Heart Problems	Mental Illness	Joint Replacements
Epilepsy	Arthritis	Stroke	Blood clots
Lung Condition	Cancer :_____	Osteoporosis	_____

Surgeries : _____

Allergies : NO YES _____

Other Medical Issues or Treatments :_____

Current Medications : See List Provided _____

INSURANCE

- TO BE COMPLETED BY OFFICE STAFF ONLY -

Primary Insurance : _____Phone : _____ Guarantor : _____

DOB of Guarantor if different from Patient :_____ Employer :_____

ID # : _____ Group # :_____ Authorization Required : YES NO

Secondary Insurance : _____Phone : _____

ACKNOWLEDGEMENT

(If over the age of 55) I have received the "Rights of the Elderly" & I have received a printed copy of the HIPAA(privacy) policy

ARE YOU PRESENTLY RECEIVING HOME HEALTH SERVICES BY ANY AGENCY? (Circle one) Yes NO

Patients who are receiving Home Health Services can <u>not</u> be seen in an out-patient facility while they are an active home health patient.

I acknowledge the above information is true to the best of my knowledge and give my permission for Hulsey Therapy Services, PC. to release information upon request to the referring and/or treating physician, insurance carrier, patient representative, or other entities who have direct affiliation with my medical care. I hereby authorize Hulsey Therapy Services, PC to provide evaluation and treatment in accordance with the Plan-of-Care established in conjunction with the treatment and/or referring physician. I authorize payment directly to Hulsey Therapy Services, PC.

Patient / Parent or Guardian Signature : _____ Date : _____