The Strength Center
PHYSICAL THERAPY

2628 Courthouse Circle, Suite A | Flowood, MS 39232 | 601.932.0305 (PH) | 601.932.0360 (FAX)

PATIENT INFORMATION

Today's Date: How did you hear about us?

Name: Email Address:

Street Address: Apt. #

City: State: Zip code:

Home Phone: Cell Phone:

Date of Birth: Social Security #

☐ Male ☐Female | ☐Married ☐Single ☐ Divorced ☐Legally Separated ☐Widowed

Race: ☐Native American ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Other ☐Declined

Emergency Contact Name: Phone #

Relationship:

Current Complaint:

Who is your Referring Physician? Primary Physican?

When is your next doctor's appointment? Recent Surgeries:

Current Medications:

Cardiac/Blood Pressure Precautions:

Allergies?

EMPLOYMENT INFORMATION

Employer's Name: Occupation:

Work Phone: If student: ☐ Full-Time ☐ Part-Time

INSURANCE INFORMATION

Primary Insurance Insurance Plan Name:

Name of Subscriber:

Patient's relationship to subscriber? ☐Self ☐ Spouse ☐ Child ☐Other

Subscriber's Date of Birth: ID #: Group #:

Subscriber's Place of Employment:

Secondary Insurance Insurance Plan Name:

Name of Subscriber:

Patient's relationship to subscriber? ☐Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Date of Birth: ID #: Group #:

Subscriber's Place of Employment:

W/C OR MVA INFORMATION

Is your injury due to a motor vehicle accident?

Is your injury work related?

Worker's Comp. Name: Date of Injury:

Contact Person: Address:

Phone Number: Fax Number:

Claim #: Case Mgr.: Phone #:

Do you have an attorney? ☐ yes ☐ no

Attorney's name: Phone Number:

Those who hope in the Lord will renew their strength… Isaiah 40:31

The Strength Center's Attendance Policy

- In order to receive maximum benefits from your rehabilitation program, it is of utmost importance that you attend your therapy appointments and follow home instructions.
- We request that if you are unable to keep your appointment that you notify the secretary 24 hours prior to your scheduled appointment.
- **It is your responsibility to schedule your appointments at least one week in advance.**
- Please be aware that your appointments may generally be on any day of the week and do not have to be set up in a specific pattern. (For example, if you are to receive treatment three times weekly, the appointments do not have to be scheduled on Monday/Wednesday/Friday).
- **It is your responsibility to inform staff members including secretaries in advance of any physician appointments.**
- Your cooperation is appreciated. We look forward to working with you and obtaining optimum outcomes from your rehabilitation program.
- If you have any questions regarding our policy content, please feel free to ask any of our staff members.
- If you would like to receive appointment reminders via email **or** text check the box below.

□Email □Text

_____

(cell phone or email address desired)

- Please sign below indicating that you understand this policy.

_____

Patient Signature

Thank you,
The Strength Center

THE STRENGTH CENTER
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Information pertaining to you and your health may be used or disclosed by The Strength Center (TSC) in order to provide you with medical treatment or services, in order to bill and receive payment for services and in order to carry out therapy services. A description of such uses and disclosures is contained in our Notice of Privacy Practices.
We are required to provide you with a copy of our Notice of Privacy Practices upon your request and to obtain your acknowledgement that you have read and understand the Notice.
By signing below, you acknowledge that you have read and understand a copy of The Strength Center's Notice of Privacy Practices.

X_____

Signature of Patient (Authorized Person) / Date

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize release of any medical data pertinent to this clinical service treatment.
Furthermore, I certify that the information provided on these forms is true and complete.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment of clinical service treatment benefits directly to the above named entity of any benefits otherwise payable to me for these services, but not to exceed the stated charge. I understand that I am financially responsible for any part of the stated charge not covered by this assignment.

X_____

Signature of Patient (Authorized Person) / Date

AUTHORIZATION AND CONSENT TO RELEASE OF MEDICAL INFORMATION

The Strength Center is hereby authorized to release information from my medical record as may be necessary for the completion of my patient care insurance.
I also authorize TSC to release medical information to my referring or follow-up physician, case manager, insurance company or other specified source, as may be pertinent to my continuing health care or for the purpose of_____.

I authorize TSC to release medical and/or billing information to _____.

Furthermore, I authorize and request that the referring source(s) release pertinent information to TSC for the purpose of insuring continued care. This authorization will remain valid up to 90 days following my discharge; however, it may be revoked at any time by notifying TSC in writing.

X_____

Signature of Patient (Authorized Person) / Date

PATIENT ADMISSION RELEASE

I hereby authorize and request The Strength Center (TSC) to carry out such orders and treatment as my physician deems necessary. I recognize that during the course of treatment, unforeseen conditions may necessitate certain diagnostic procedures and treatment and I therefore authorize the employees of TSC to perform such procedures as are in the exercise of their professional judgment necessary and desirable. I am aware that the practices of medicine are not an exact science and acknowledge that no guarantees have been made to me concerning the result of my treatment.
For and in consideration of clinic services rendered and to be rendered to the below named patient, the understood hereby jointly and severally agree (if there be more than the signing party) to pay us and when due the reasonable charges of TSC for care and treatment furnished to the undersigned. It is understood that such charges, above those covered by the third party payers (i.e. Blue Cross) are due and payable in full upon discharge of patient. Authorization is hereby granted to release to my insurance company or companies such information as may be necessary for the completion of my clinical service claims.

X_____

Signature of Patient (Legal Guardian / Closest Relative) / Date

If person *other than* Patient, Legal Guardian or Closest Relative guaranteeing bill, sign above