Patient demographics Today's date: ______________________________

Name: ____ Date of birth: ______________________________

Address: ____

City: _______________________________ State:_______________ Zip: _______________________________

Phone: cell: ________________________________ home: ______________________

Date of birth: ______________________________ Age: ________________________

Chief complaint:____

Who can we thank for referring you?____

Emergency contact:_______________________________________ phone: ____________________________

Is your injury related to a motor vehicle accident? Yes /No

If you answered yes, please complete questions 1-5, otherwise skip to signature line.

1. Date of injury: ____
2. do you have an attorney? Name/phone number: ____
   ____
3. Auto insurance company: ____
4. Adjustor name: ___________________________________phone number:______________________
5. Claim number: ____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorized Freedom Physical Therapy, LLC to release any information acquired in the course of my treatment necessary to process insurance claims. I hereby consent to treatment as deemed necessary by the treating physical therapist(s) and referring physicians(s).

CANCEL / NO-SHOW: We reserve the right to charge the patient or legal guardian $60.00 for a no-show charge for not canceling the patient's appointment at least 24 hours prior to the scheduled appointment.

I certify that I have read and understand the above hold harmless clause and release of information clause. The information I have provided on this form is true and correct to the best of my knowledge. A copy of this form is valid as the original.

X____ date:______________________________

Patient/legal guardian signature