PREMIER
PHYSICAL THERAPY & SPORTS MEDICINE

**AUTO INJURIES, WORK INJURIES ans PERSONAL INJURIES ONLY – please complete this section**

INJURY DATE: _____ INJURY TYPE: ☐ Work ☐ Auto ☐ Slip / Fall ☐ Other

If work related, did you report this to your employer? ☐ YES ☐ NO Claim #_____

If an auto accident, in what state did the accident occur? _____

Have you filed a claim for this injury? ☐ YES ☐ NO Claim #_____

Insurance Company _____ Phone _____

Address _____ Contact Person_____

Do you have an attorney? ☐ YES ☐ NO Name_____

## *Missed Appointment Policy*

**ALL PATIENTS PLEASE READ:**

- Make every effort to attend all or your scheduled therapy sessions. This will speed your recover process.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time another patient and get your appointment rescheduled to a more convenient time.
- There is a $25.00 charge for missing an appointment without cancelling.
- If you miss two or more appointments without cancelling, we reserve the right to cancel all of your future appointments and require that you obtain a new referral from you physician to re-start treatment.

**INITIALS** _____

**WORKERS COMPENSATION PATIENTS PLEASE READ:**

- Make ever effort to attend all of you scheduled therapy sessions. this will speed your recovery process.
- If you are unable to attend an appointment, please let
- us know 24-hours in advance so we can offer your treatment time to another patient and get your appointment rescheduled to a more convenient time.
- If you miss two or more appointments without cancelling, we will notify your physician, workers compensation insurance carrier and your employer that you are not attending your scheduled appointments. We also reserve the right to cancel all of your future appointments and require that you obtain a new referral from your physician to re-start your treatment.

**INITIALS** _____

## *Consent to Treat*

I, the undersigned, hereby voluntarily authorize Premier Physical Therapy & Sports Medicine to perform outpatient diagnostic evaluation and/or procedures and to administer such outpatient therapy that is necessary and appropriate. I understand that physical therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

## *Authorization to Release Information*

I, the undersigned, hereby voluntarily authorize Premier Physical Therapy & Sports Medicine and the attending physician to release information relative to any outpatient therapy treatment administered to any third-party payor(s) financially responsible for these services or my referring and/or primary care physician or therapist.

## *Acknowledgment of Terms*

By signing below, I attest that all the information given is true and accurate to the best of my ability and that I have read and understand the policies stated above.

PATIENT SIGNATURE:_____ Date:_____

WITNESS SIGNATURE:_____ Date:_____


PORT ST. LUCIE
1680 SE Lyngate Dr., Suite 203
Port St. Lucie, FL 34952
Phone (772) 335-7966
Fax (772) 335-7963

FORT PIERCE
2217 South 25th Street
Fort Pierce, FL 34950
Phone (772) 464-6424
Fax (772) 464-4324

ST. LUCIE WEST
160 NW Central Park Plaza, Ste. 108
Port St. Lucie, FL 34987
Ph. (772) 621-9313
Fax (772) 621-9358

STUART
2220 SE Ocean Blvd., Ste. 202
Stuart, FL 34996
Ph. (772) 283-4713
Fax (772) 283-4715

JENSEN BEACH
897 NE Jensen Beach Blvd.
Jensen Beach, FL 34957
Phone (772) 324-3081
Fax (772) 232-6282