In-Motion Physical Therapy Services
10557 Church Road
Dallas, TX 75238
214-348-3516, (FAX) 348-5727

PATIENT INFORMATION RECORD

NAME: ____
First Middle Last

ADDRESS: ____
Street Apt. # City State Zip Code

HOME PH: ____________________BUSINESS PH: ___________________CELL PH: ________________________

DATE OF BIRTH: _____ / _____ / _______ Sex: ☐ M ☐ F AGE: _________

MARITAL STATUS: ☐ S ☐ M ☐ OTHER SPOUSE'S NAME: ____

EMPLOYMENT STATUS: ☐ EMPLOYED FT ☐ EMPLOYED PT ☐ UNEMPLOYED ☐ FT-STUDENT ☐ PT-STUDENT

NAME OF EMPLOYER: ____

ADDRESS: ____ CITY: __________STATE: _______ ZIP: _________

IS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO AUTO ACCIDENT? ☐ YES ☐ NO

OTHER ACCIDENT? ☐ YES ☐ NO IF OTHER ACCIDENT, DESCRIBE:

____

WHOM MAY WE THANK FOR YOUR REFERRAL? ____

IN CASE OF EMERGENCY

NAME: ____ RELATIONSHIP TO PATIENT: __________________

TELEPHONE NO.: ___________________________

CONSENT OF PHYSICAL THERAPY PROCEDURES

1. I HEREBY AUTHORIZE THE PERFORMANCE OF PHYSICAL THERAPY PROCEDURES ON PARTS OF MY BODY, BY MICHELE FIRRA WARD, PT, OR OTHER THERAPISTS, AS PRESCRIBED BY MY PHYSICIAN.

2. I CONSENT TO THE ADMINISTRATION OF SUCH PROCEDURES AND THE PERFORMANCE OF APPROPRIATE PROCEDURE WHICH MICHELE FIRRA WARD, PT, OR OTHER THERAPISTS, IN THE EXERCISE OF JUDGMENT, MAY CONSIDER NECESSARY OR ADVISABLE.

3. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN TO ME BY MICHELE FIRRA WARD, PT, OR OTHER THERAPISTS, WITH REGARD TO THE RESULTS WHICH MAY BE OBTAINED BY MY TREATMENT.

4. I AUTHORIZE IN-MOTION PHYSICAL THERAPY SERVICES TO SEND MY MEDICAL INFORMATION, INCLUDING BUT NOT LIMITED TO MY PROGRESS IN PHYSICAL THERAPY, TO MY REFERRING PHYSICIAN.

CANCELLATION POLICY

I UNDERSTAND THAT IF I CANCEL MY SCHEDULED APPOINTMENT WITH LESS THAN 24 HOURS NOTICE OF MY APPOINTMENT, AND THIS OCCURS 2 TIMES, I WILL BE CHARGED FOR THE FULL AMOUNT OF ONE MISSED APPOINTMENT. ______ (PATIENT INITIALS)

DATE: _______________________ SIGNATURE: ____