In order to submit this form, you should open it with Adobe Acrobat Reader.

Name *

First Name Last Name

Address *

Street

City State

Zip Code

Email *

Home #

Cell # *

Work #

Date of Birth *

Sex *

- ☐ Male
- ☐ Female
- ☐ Intersex

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1.1. Emergency Contact

Name *

First Name Last Name

Relationship *

Relationship

Phone *

Phone Number

1.2. Physician's Information

Referring Physician's Name (or write 'Self' if self-referred) *

Physician Name

Referring Physician's Phone

Physician Phone

Diagnosis or Affected body part *

Diagnosis of body part

Related Cause *

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- [ ] Auto Accident
- [ ] Fall
- [ ] Employment Injuiry
- [ ] Sports Injury
- [ ] Surgery
- [ ] None of the Above

Have you previously seen a Chiropractor, Acupuncturist, or Physical therapist for this injury? *

- [ ] Yes
- [ ] No

 # Visits

Number of Visits

1. Fever, chills, or night sweats? *

- [ ] Yes
- [ ] No

2. Unexplained weight loss/gain *

- [ ] Yes
- [ ] No

3. Malaise (feeling generally unwell) *

- [ ] Yes
- [ ] No

4. Unusual fatigue *

- [ ] Yes
- [ ] No

5. Nausea/vomiting *

- [ ] Yes
- [ ] No

6. Numbness/tingling *

- [ ] Yes
- [ ] No

7. Weakness *

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☐ Yes
☐ No

8. Dizziness/lightheadedness/loss of consciousness *

☐ Yes
☐ No

9. Chest pain/palpitations *

☐ Yes
☐ No

10. Swelling in feet/hands *

☐ Yes
☐ No

11. Difficulty breathing/shortness of breath *

☐ Yes
☐ No

12. Difficulty breathing when lying down *

☐ Yes
☐ No

13. Cough/change in cough/blood in phlegm *

☐ Yes
☐ No

14. Wheezing *

☐ Yes
☐ No

15. Difficulty swallowing *

☐ Yes
☐ No

16. Heartburn/Indigestion *

☐ Yes
☐ No

17. Change in appetite *

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☐ Yes
☐ No

18. Specific food intolerance/nausea/vomiting *

☐ Yes
☐ No

19. Bowel pattern changes (color/texture/frequency) *

☐ Yes
☐ No

20. Difficulty urinating (starting/stopping) *

☐ Yes
☐ No

21. Urine frequency changes *

☐ Yes
☐ No

22. Name all diagnosed medical conditions and emergencies either existing or in the past:

Please check if you have the following conditions:

23. Diabetes *

☐ Yes
☐ No

24. High Blood Pressure *

☐ Yes
☐ No

25. Osteporosis *

☐ Yes
☐ No

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26. Cancer/or History of Cancer *

- ☐ Yes
- ☐ No

27. Pacemaker *

- ☐ Yes
- ☐ No

28. Osteopenia *

- ☐ Yes
- ☐ No

29. Stroke *

- ☐ Yes
- ☐ No

30. Heart Condition *

- ☐ Yes
- ☐ No

31. Pregnancy *

- ☐ Yes
- ☐ No

32. Asthma *

- ☐ Yes
- ☐ No

Please list any medications you are taking:

Please list any allergies:

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33. Are you allergic to Latex? *

- ☐ Yes
- ☐ No
- ☐ Unsure

34. Are you allergic to adhesive tape (medical tape)? *

- ☐ Yes
- ☐ No
- ☐ Unsure

1. CONSENT: I hereby request and consent to receive physical therapy treatments and related procedures from Sean Hampton of Sean Hampton Global Physical Therapy Corp, within the scope of physical therapy practice. *

- ◯ I agree

2. ACKNOWLEDGMENT OF RIGHTS: I understand that I have the right to refuse or discontinue any part of my physical therapy treatment at any time, prior to or during the procedure, should I experience any discomfort, pain, or have other concerns. I acknowledge that I have the right to be fully informed about my treatment plan, which is based on my medical history, physical therapy diagnosis, symptoms, and examination findings. Furthermore, I have the right to discuss with my therapist the potential risks, benefits, and alternatives related to the proposed treatments.I acknowledge that physical therapy, like all medical treatments, carries inherent risks, including but not limited to soreness, injury, or other complications. By signing below, I voluntarily consent to receive physical therapy treatment and agree to fully cooperate and participate in the prescribed therapy plan. *

- ◯ I agree

3. PRIVACY PRACTICES POLICY: The terms of this Notice of Privacy Practices apply to Sean Hampton Global Physical Therapy, including its employees, subsidiaries, affiliates, and related entities. These entities may share your protected health information (PHI) as necessary to provide treatment, process payment, and conduct healthcare operations, as allowed by law.We may share your health information with those you authorize who assist you with treatment or payment. We are required to notify government authorities if we suspect abuse, neglect, or domestic violence. We may disclose information to law enforcement, federal, or military officials as required by law. Except as noted above or when required by law, we will not disclose your health information without your written consent.You have the right to request restrictions on how your health information is used or disclosed and to request confidential communication methods or locations. You also have the right to access and obtain copies of your health and billing records upon submitting a completed request form and payment. If you believe your health records are

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inaccurate or incomplete, you may request corrections. Additionally, you have the right to request a record of disclosures of your health information made for reasons other than treatment, payment, or healthcare operations. You may receive a copy of this Notice of Privacy Practices at any time and file a complaint if you believe your privacy rights have been violated. A copy of any updated Notice of Privacy Practices will be provided to you upon request, including via email. *

- ◯ I agree

4. APPOINTMENT REMINDER: As a courtesy, our office provides automatic appointment reminders the day before your scheduled visit. Please select your preferred reminder method below: *

- ◯ Call
- ◯ Text
- ◯ Email
- ◯ I prefer NOT to receive appointment reminders

5. PAYMENT POLICY: Payment is due at the time services are provided. I authorize the use of my credit card on file or will pay via cash, Zelle, or Venmo for services rendered. *

- ◯ I agree

6. NO-SHOW & CANCELLATION POLICY: When you schedule an appointment, that time is specifically reserved for you. If you are unable to keep your appointment, you must cancel at least 24 hours in advance, during our business hours (Monday–Friday, 8:00 am to 6:00 pm) via phone, text, or email. Cancellations with less than 24 hours' notice or missed appointments (no-shows) will be charged the full rate of the scheduled visit (office or home visit, as applicable). By signing below, I acknowledge and accept that I will be personally responsible for any no-show or late cancellation fees. *

- ◯ I agree

Expiration Date *

Mes Día Año

9. SUPERBILL REQUEST: We do not bill your insurance directly; however, we can provide you with a Superbill to submit to your insurance company for reimbursement. To process your Superbill, please provide a clear photo or copy of your insurance card (front and back), ensure you have a current referral from your Medical Doctor, and that all visits are paid in full. Please let us know if you'd like us to provide you a Superbill? *

- ◯ Yes
- ◯ No

7. CREDIT CARD ON FILE POLICY: We require a credit card on file to secure your appointment. This card may be charged, at the company's discretion, in cases of no-shows, late cancellations, or overdue payments. Our policy is to receive payment on the day of service by check, Venmo, Zelle or credit card. If payment is not made that day or a late cancellation fee/no-show occurs, the

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card on file may be used. While you are welcome to pay via cash, Venmo, or Zelle, we kindly ask for a card on file to help uphold our cancellation and payment policies efficiently.

Credit Card Number *

Please enter the 15 or 16-digit number found on the front of your card.

10. ACKNOWLEDGMENT AND AGREEMENT: I have read and fully understand the above-referenced policies and do hereby agree to comply as specified. I acknowledge that a photocopy or digital copy of this authorization is as valid as the original. *

- ◯ I agree

8. CHECK RETURN POLICY: If a check is returned by the bank due to non-sufficient funds (NSF), our office will charge a $25.00 fee per returned check, in addition to the amount due for the services rendered. *

- ◯ I agree

Name of Patient or Guardian Signature *

First Name Last Name

Date *

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