MCLAUGHLIN JUDD PHYSICAL **THERAPY, PLLC**

NAME: (Last) _____ (First) _____ SS# _____

ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

PHONE: (H) _____(C) _____ (W) _____

DOB: ____ / _____/ _____ SEX: MALE / FEMALE MARRIED: Y / N

REFERRING PHYSICIAN: _____ OFFICE LOCATION: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED BY: DOCTOR / FRIEND / FAMILY / OTHER: _____

****Returning patients only:**
****Revision Date_____ Initials: _____**

- Are you currently receiving any type of treatment from a certified home healthcare agency? YES / NO
- Have you ever received any physical therapy or chiropractic care for the same body part? YES / NO If yes, when? _____

Please notify the front desk if you've had previous treatment as your physical therapy benefits may be affected.

We would like to E-mail you our *free* quarterly Injury Prevention newsletter as well as update you to any news regarding our practice. Please provide us with your E-mail address below so we can add you to our list! McLaughlin Judd Physical Therapy, PLLC will not sell or share your email address with *any* third party.

E-MAIL ADDRESS: _____

Direct Access (Self-referred)
Notice of Advice

I understand that physical therapy may not be a covered service by my healthcare plan or insurer without a prescription from a physician, dentist, podiatrist, or nurse practitioner. It is my responsibility to determine if a prescription is required by my insurer in order to cover my physical therapy services. I understand that direct access to physical therapy is limited to **10 visits within 30 days from the initial treatment date.** I authorize physical therapy treatment to be provided by:

Physical Therapist Signature: _____
Service Address: _____
_____

_____ _____
Patient's Signature Beginning Date of Service