ICONIC WELLNESS
PHYSICAL THERAPY AND WELLNESS SERVICES

Patient Information

First Name:		Street Address:	
MI:		City:	
Last Name:		State:	
Date of Birth:		Zip Code:	
Email Address:		Primary Care Provider:	
Marital Status:		Primary Care Provider #:	
Work Status:			

Home Phone:	
Work Phone:	
Cell Phone:	

Insurance Information

Primary Insurance:		Policy Number:	
Policy Holder Name:		Group Number:	
Relationship to Policy Holder:		Policy Holder's Employer:	
Holder's Birth Date			

Emergency Contact

Contact Name:		Contact Number:	

Medical History

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Reason for Therapy:		Date of Injury/Onset	
Cause of Injury/Onset			

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐ Diabetes	☐ Heart murmur	☐ Crohn's disease
☐ High blood pressure	☐ Pneumonia	☐ Colitis
☐ High cholesterol	☐ Pulmonary embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Jaundice
☐ Goiter	☐ Emphysema	☐ Hepatitis
☐ Cancer (type) _____	☐ Stroke	☐ Stomach or peptic ulcer
☐ Leukemia	☐ Epilepsy (seizures)	☐ Rheumatic fever
☐ Psoriasis	☐ Cataracts	☐ Tuberculosis
☐ Angina	☐ Kidney disease	☐ HIV/AIDS
☐ Heart problems	☐ Kidney stones	

Surgical History:

Other medical conditions (please list):

CURRENT MEDICATIONS

Drug allergies: ✈ No ✈ Yes To what:

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**Name of drug**	**Dose (include strength & number of pills per day)**
1.		7.	
2.		8.	
3.		9	
4.		10.	
5.		11.	

Signature: _____ **Date:** _____

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Patient Consent

Consent to Treatment

I consent to receive rehabilitation and physical therapy services at Iconic Wellness. I understand and acknowledge that physical therapy and rehabilitation services may involve bodily touch and contact. I understand that no guarantees are made regarding results and treatment provided.

Initials: _____

Financial Responsibility

I understand that I have a responsibility to ensure payment in full for the fees and bills that occur as a result of treatment at Iconic Wellness. While Iconic Wellness will verify coverage and bill insurance, I am still financially responsible for the payment and any outstanding balances. I also understand that the cancellation policy requires me to give a 24-hour notice if I am unable to attend my appointment. If I fail to notify Iconic Wellness of a cancellation without a 24-hour notice, I agree to pay a $25 fee.

Initials: _____

Payment Authorization

I assign all benefits to Iconic Wellness, in addition to authorizing the release of medical records as necessary to process medical claims.

Initials: _____

Guardian Consent (For patients under 18 years of age)

I (the parent/guardian) of a minor agree that I have been advised to be present during any treatment or services rendered, and I understand that I waive all claims I have if I fail to be present for any treatment or services rendered.

Initials: _____

Waiver

I hereby fully and forever release and discharge Iconic Wellness, LLC and its related parties from all liability, in addition to all claims, demands, damages, rights of action, present and future as a result from my refusal to accept/receive medical services.

Initials: _____

Privacy Policy Receipt

I acknowledge that I have received and reviewed the Privacy Policy.

Initials: _____

Disclosure of Medical Records

I authorize Iconic Wellness to release any information or documentation to the following parties:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Initials: _____

Signature: _____ **Date:** _____