at The Center for Personal Growth

151 Second Street, S. W. – Winter Haven, FL 33880
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E-mail: jann@turningpointeptandfitness.com

NEW PATIENT INFORMATION

NAME____ BIRTHDATE _____/____/_____
Last First MI Month Day Year

ADDRESS ____

______________________________ _____________ _______________
City State Zip Code

PATIENT CONTACT INFORMATION
(PLEASE LIST ALL NUMBERS AND CHECK THE EASIEST WAY TO REACH YOU)

☐ HOME: ___________________________ ☐ WORK: ________________________________

☐ CELL: ____________________________ ☐ E-MAIL: ________________________________

WOULD YOU LIKE PATIENT STATEMENT BY: E-MAIL ________ OR PRINTED _________

EMPLOYER: ____

REFERRING PHYSICIAN: ____

HOW WERE YOU REFERRED HERE? ____

EMERGENCY CONTACT: ______________________________ _________________ ___________________
Name Phone # Relationship

CONSENT TO TREATMENT

I hereby consent to evaluation and initiation of treatment by Turning Pointe at The Center for Personal Growth.

Patient/Responsible Party Signature ____ Date: _______________

* * * * CONSENT (FOLLOWING EVALUATION) / AUTHORIZATION * * *

I hereby consent to further treatment by Turning Pointe Physical Therapy at The Center for Personal Growth. The therapist has reviewed my diagnosis with me and discussed the outcome of my evaluation, the plan for my treatment, benefits expected and the associated risks and alternatives. My questions have been fully answered and I agree with the plan for treatment. I do realize that I may opt to withdraw my consent for treatment at any time.

I understand that Jann Lawlor, P.T., DPT is a physical therapist, who is a specialist in the evaluation and treatment of neuromuscular dysfunction to reduce pain and restore function. I understand that Dr. Jann Lawlor specializes in the ultimate goal of achieving the highest of wellness and function at Turning Pointe Physical Therapy at The Center for Personal Growth and her emphasis is primarily on maintenance of optimal physical health through regular physical therapy oriented assessment. This goal is achieved through manual therapy and personalized home exercise instruction. Advice on home care remedies is emphasized, in conjunction with hands on manual skills. If it becomes obvious that more involved physical therapy sessions are warranted or medical doctor input is needed, appropriate referral or recommendation will be given throughout the treatment process.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO PAY THE ENTIRE BILL. I HAVE FULL UNDERSTANDING OF THE FEE SCHEDULE AT TURNING POINT Physical Therapy AT THE CENTER FOR PERSONAL GROWTH AND HAVE BEEN REVIEWED ON THE CANCELLATION POLICY. I also authorize Turning Pointe Physical Therapy at The Center for Personal Growth to release any and all medical records to my physician, and /or insurance carrier if required for payment of charges.

Patient/Responsible Party Signature____ Date ________________

Therapist Signature ____ Date _________________