Date:_____

New Patient Information

Name: _____ Date of Birth: _____

E-mail Address: _____ Primary Care: _____

Reason for Therapy: _____

□ Speech Therapy □ Occupational Therapy □ Physical Therapy

History of Current Issue:

Are you currently taking any medications (prescription and/or over the counter medicines)? Please, specify:

Have you had any of the following diagnostic, medical or rehabilitative services for this issue? Check the appropriate box or boxes:

□ Chiropractor
□ Massage Therapy
□ Speech Therapy
□ Occupational Therapy
□ Physical Therapy
□ General Practitioner
□ MRI
□ Neurologist
□ Orthopedist
□ Podiatrist
□ X-Rays
□ Emergency Room
□ Inpatient Rehab
□ Myelogram
□ Other

Do you now or have you ever had any of the following? Please check appropriate box or boxes:

□ Asthma, Bronchitis, or Emphysema
□ Anemia
□ Heart Attack or Surgery
□ Coronary Heart Disease or Angina
□ Gout
□ Dizziness or Fainting
□ Emotional/Psychological Problems
□ High Blood Pressure
□ Shortness of Breath / Chest Pain
□ Diabetes I or II
□ Thyroid Trouble/Goiter
□ Cancer / Chemotherapy / Radiation
□ Weakness
□ Infectious Diseases

□ Hernia
□ Numbness or Tingling
□ Severe or Frequent Headaches
□ Osteoporosis/ Osteopenia
□ Neck / Shoulder Injury/Surgery
□ Sleeping Problems/Difficulties
□ Blood Clot / Emboli (DVT/PE)
□ Epilepsy / Seizures
□ Pacemaker?
□ Joint Replacement of _____
□ Currently Pregnant / Trying to Conceive
□ Neurological Condition

□ Bowel or Bladder Problems
□ Allergies, *Specify*: _____
□ Elbow / Hand Injury
□ Vision or Hearing Difficulties
□ Stroke / TIA
□ Back Injury / Surgery
□ Ankle / Foot Injury / Surgery
□ Knee / Hip Injury/Surgery
□ Arthritis/Swollen Joints
□ Unintentional Weight Loss/Energy Loss
□ Tobacco / Cigarette Use
□ Other, *Specify:*_____

Please list any additional information about your health or any medical conditions you have not listed above:

What are your expectations or goals for therapy?

I have truthfully answered these questions about my medical history and condition and provided information about my current medications and medical care.

_____ _____
Signature Date

_____ _____
Relationship to Patient Witness

Financial Responsibility

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. The patient is responsible for charges incurred, regardless of insurance coverage. If has a contract with the patient's insurance carrier, will file the claim for patient's services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I understand that I am responsible for all balances due. assignments for

I understand, in some instances, all or some of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I understand that it is my responsibility understand my insurance benefits and comply with the requirements of the policy.

_____ Initial here that I have read, agree with, and understand the above statements.

Appointment Times and Scheduling

All appointments are expected to last minutes in length. will contact the patient or caregiver prior to, or the morning of the appointment to confirm appointment time. respects patient's time and makes every effort to arrive on schedule. However, because an employee cannot anticipate what every person will need, or if medical emergencies arise, she will take whatever time is necessary to give each and every patient the best care that is needed. As employees makes home visits, one cannot foresee challenges in parking, heavy traffic, or unforeseen road conditions. For this reason therapists will give a window between thirty to sixty minutes before or after the appointment time of arrival. If therapist is running more than thirty minutes late then patient will be called and notified and given the opportunity to reschedule without a cancellation / no show fee.

_____ Initial here that I have read, agree with, and understand the above statements.

Travel Fee

travels to treat patients in an area within . Whenever the schedule permits, a therapist will travel outside this area to service patients for an additional travel fee. At times, patients on the outskirts of this service area may qualify for the travel fee due to the distance from the therapist's point of origin. therapists retain the right to decline admitting or treating patients who live outside the service area, or decline patients who live in conditions that are not suitable for therapy due to safety reasons.

_____ Initial here that I have read, agree with, and understand the above statements, I live outside service area, and agree to pay the travel fee of $_____ per visit.

_____ Initial here that I have read, agree with, and understand the above statements, and the travel fee does not apply to me.

Cancellations and Missed Appointments

In the event that the patient is unable to keep an appointment please contact your therapist as quickly as possible. Visits that are cancelled only two hours prior to visit time, or are not cancelled at all will be billed $50 due to scheduling / traveling inconveniences. E-mail is a suitable means to communicate visit cancelation if message is sent twenty-four hours prior to visit start time. In the case of a true medical emergency, the cancellation fee will be waived.

_____ Initial here that I have read, agree with, and understand the above statements.

Informed Consent to Treatment

Physical, Occupational, and Speech Therapy involves the use of many different types of physical evaluation and treatment. The patient should understand that a Physical, Occupational and Speech Therapy diagnosis are not a medical diagnosis by a physician or based on radiological imaging and that health plan or insurer might not cover such services.

As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict the patient's response to a certain modality or procedure. It is impossible to predict an individual patient's reaction to a particular treatment might be, nor can it be guaranteed that the treatment will help the condition the patient is seeking treatment for. There is also a small risk that the treatment may cause pain or injury, or may aggravate previous existing conditions. The patient has the right to ask the physical therapist what type of treatment she is planning based on medical history, diagnosis, symptoms and testing results. The patient may ask the therapist about the potential risks and benefits of a specific treatment. The patient has the right to decline any portion of the treatment at any time before or during the treatment session.
Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If the patient has any questions regarding the type of exercise that he/she is performing and any specific risks associated with these exercises, the therapist will be glad to answer them.

I acknowledge that a therapist has explained my treatment program, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical, Occupational, or Speech Therapy as outlined to me, and wish to proceed.

_____ _____

Signature Date

_____ _____

Relationship to Patient Witness

Patient Privacy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that has the right to change her Notice of Privacy Practices from time to time and that I may contact **the office** at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand is not required to agree to my requested restrictions, but if the owner does agree than she is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that has taken action relying on this consent.

_____ Initial here that I have read, agree with, and understand the above statements.

Concerns and Complaints

If the patient is concerned that has violated privacy rights or if the patient or caregiver disagree with any decisions we have made please contact

I have read and fully understand may use or disclose my personal health information, without limitations, for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, patient trend studies and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____ Initial here that I have read, agree with, and understand the above statements.

Patient Media Release

I hereby grant permission to the staff of to use images, likenesses, audio or any other data (heretofore referred to as "Media") obtained through my treatment for instructional, educational or research purposes. This included all photos, videos, audio recordings, charts, graphs, analysis or any other data obtained by or submitted to the staff of in the course of my treatment. The Media may be used in any professional manner that deems necessary and I understand that the Media belongs to and I will not receive any compensation or payment in connection to their use.

I assume the risks involved in releasing this information and release and it's employees and contractors from any and all liability that could arise from the use of this Media.

_____ Initial here that I have read, **agree with**, and understand the above statements.

_____ Initial here that I wish to **opt out** of media participation.

Consent to Email / Text for Appointment Reminders Or Healthcare Matters

Patients in this practice may be contacted via e-mail and / or text messaging to be reminded of an appointment, to obtain feedback on their experience with this healthcare team, and / or to provide general health reminders / information.

If at any time I provide an e-mail or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that e-mail or text address from staff.

1. ____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or e-mails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The e-mail that I authorize to receive e-mail messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in the patient's wireless plan (contact cell carrier for pricing plans and details).

2. ____ (Patient Initials) I hereby revoke my request for future communications via e-mail and / or text messages.

3. ____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

_____ _____
Signature Date

_____ _____
Relationship to Patient Witness