INFORMED CONSENT

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I authorize the release of medical information to my referring physician. I hereby assign all medical benefits to be paid directly to PT Plus.

I also understand that PT Plus requires payment at the time of service for co-pays, co-insurance, and deductibles and any non-covered supplies or products. I am aware of the prices for services and products. I am aware that PT Plus will submit charges for services to my insurance company unless I make other arrangements. I am also aware that PT Plus expects payment of my balance within 7-10 days after receiving a statement.

I realize I am responsible for all charges incurred, and authorizations required, regardless of payment by my insurance company, with the exception of any HMO's for which PT Plus has a signed contract as a participating provider. Any charges not paid by my insurance carrier, other than with those HMO's contracting with PT Plus as a participating provider, will become my responsibility.

I understand that there is some risk involved when undergoing physical therapy and exercise. I agree to hold harmless PT Plus and its agents from any and all liability in the performance of their services.

I assign any proceeds from any cause of action, whether from a court award or settlement, in the hands of my attorney, the responsible party, or the insurance carrier for the responsible party, to PT Plus. I authorize and direct my attorney to pay all outstanding bills to PT Plus from the proceeds of any settlement. A monthly finance charge of 5% will be applied to my balance after thirty (30) days. If it becomes necessary for my account to be assigned to a collection's agency, I agree to pay all collection costs and attorneys' fees. This will include legal fees at a rate of 32% of the outstanding balance.

I understand that there is a sixty-dollar ($ 60.00) handling fee for "no shows" and cancellations of appointments without providing twenty-four (24) hour notice.

______________________________ ____________________

Patient Signature Date

____

Parent or Legal Guardian

Physical Therapy & Wellness Centers

Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are required to follow certain rules of privacy that may affect out patients' personal health information.

Uses and Disclosures

PT Plus may use your personal health information about you and health information about your ailment or condition in communication with your healthcare team. Your physical therapist may share information with you verbally and/or in writing with your physician(s) in order to carry out your plan of care. If you would like to pursue insurance reimbursement for our services, insurance companies often require private health information in order to process the claims we may print for you to submit to them for your reimbursement.

Individual Rights

Under HIPAA, every individual receiving care has the right to privacy of personal health information. These rights apply to verbal communication, as well as written information. You have the right to your medical records, after signing an authorization form.

Our Responsibilities

The staff at PT Plus understands your rights and is sensitive to the importance of the privacy rules. It is our duty to do the following:

- Handle only the minimum personal health information necessary and required by insurance carriers for printing claims for your reimbursement.
- Use discretion when discussing your ailment and treatment with you, members of your therapy team, your physician, by phone or in person (will move to a more private room and lower our voices)
- Use discretion when sending written information to your physician either by mail or by fax
- Refrain from using e-mail to transmit any of your health information
- Not share your personal health information with any unauthorized entities
- Keep charts in secure areas at all times
- Maintain confidentiality

Complaints

If you feel your privacy rights have been violated, you may contact Laura Coleman, PT, ATC, at (434) 823-7628 to report your complaint. As the owner, I want to know about any problems within our organization so that we can remedy them as quickly as possible. I will respect confidentiality of all complaints.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of PT Plus' **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original.

Signed: ______________________________ Date: ______________

Name: ______________________________
(please print)

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: __________________ Witnesses by: __________________

Please bring this signed form with you to your first session with the Physical Therapist.

Thank you !

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): ________________________________

By: (name and title): ________________________________

Medical History Questionnaire

ALLERGIES: Are you latex sensitive? ❑ Yes ❑ No List any allergies we should know about: ____________________

Name: ____________________

Please check any of the following whose care you are under currently:

❑ Medical Doctor ❑ Psychologist/Psychiatrist ❑ Other:
❑ Osteopath ❑ Physical Therapist
❑ Dentist ❑ Chiropractor

Height ________ Weight ________

PAST MEDICAL HISTORY:

Have you *ever* been diagnosed as having any of the following conditions?:

Yes	No		Yes	No	
❑	❑	Cancer ____________	❑	❑	Thyroid Problems
❑	❑	Heart Problems	❑	❑	Diabetes
❑	❑	Circulation Problems	❑	❑	Arthritis (Rheumatoid, Osteo-, etc.)
❑	❑	Infection (staph, strep, C-diff, etc.)	❑	❑	Chemical Dependency/Addiction (i.e., alcoholism)
❑	❑	High blood pressure	❑	❑	Multiple Sclerosis
❑	❑	High cholesterol	❑	❑	Epilepsy
❑	❑	Angina or chest pain	❑	❑	Depression
❑	❑	Asthma	❑	❑	Hepatitis
❑	❑	Emphysema / Bronchitis	❑	❑	Stroke
❑	❑	Tuberculosis / Other Lung Disease	❑	❑	Anemia
❑	❑	Kidney Disease	❑	❑	Other: ____________

During the past month, have you been feeling down, depressed or hopeless? ❑ Yes ❑ No
During the past month, have you been bothered by having little interest or pleasure in doing things? ❑ Yes ❑ No
Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way? ❑ Yes ❑ No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

Please list any significant injuries, surgeries, or hospitalizations, including the approximate date and reason.

		REASON FOR INJURY/SURGERY/HOSPITALIZATION
1.	________	____________________
2.	________	____________________
3.	________	____________________

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following? (Check those that apply.)

❑ Diabetes ❑ Cancer ❑ Tuberculosis
❑ Arthritis ❑ Heart Disease ❑ Anemia
❑ High Blood Pressure ❑ Headaches ❑ Stroke
❑ Epilepsy ❑ Kidney Disease ❑ Mental Illness
❑ Alcoholism / Chemical Dependency

Please list any PRESCRIPTION OR OVER THE COUNTER MEDICATIONS you are currently taking. (INCLUDING pills, injections, and/or skin patches): you may attach a separate list

	MEDICATION	DOSAGE
1.	____________________	____________
2.	____________________	____________
3.	____________________	____________

How many caffeinated beverages (coffee or other beverages) do you drink per day? ________

How many packs of cigarettes do you smoke per day? ________
How many days per week do you drink alcohol? ________

If one drink = one beer or glass of wine, how many do you drink in an average sitting? ________

Have you recently noted the following:

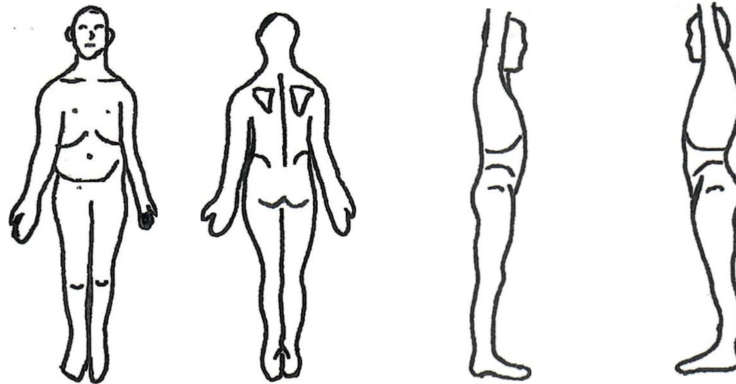
❑ Yes ❑ No Weight Loss or Gain
❑ Yes ❑ No Nausea / Vomiting
❑ Yes ❑ No Dizziness / Light Headedness
❑ Yes ❑ No Fatigue
❑ Yes ❑ No Weakness
❑ Yes ❑ No Fever / Chills / Sweats
❑ Yes ❑ No Numbness or Tingling

Do you have any medical problems that would limit your ability to exercise? ❑ Yes ❑ No

____________________ ________ ____________________ ________
Patient's Signature Date Physical Therapist's Signature Date

PATIENT HISTORY

Name_______________________________ Date___________________



1. Where are your symptoms located ? (Darken areas on body diagrams above.)
2. When did your symptoms begin ? ______________________________________
3. Are your symptoms related to:
   ❑ Accident ❑ Trauma ❑ Gradual Onset ❑ Work-Related Injury describe:
   ____
4. What makes you feel better ? ______________________________________
5. What makes you feel worse ? ______________________________________
6. Circle the words that best describe your symptoms:
   ❑ <u>Sharp</u> ❑ <u>Ache</u> ❑ <u>Burning</u> ❑ <u>Tingling</u> ❑ <u>Stabbing</u> ❑ <u>Throbbing</u>
7. What Level is your Pain, on a scale of 0 to 10, with 0 being None, and 10 the worst pain imaginable? ____________________________
8. Even if unrelated to the current ailment, have you (check the one that best applies):
   - ❑ I have had 0 falls in the past 1 year
   - ❑ I have had 1 fall in the past 1 year, <u>without</u> injury
   - ❑ I have had 1 fall in the past 1 year, <u>with</u> injury
   - ❑ I have had 2 or more falls in the past 1 year
9. Have you been seen <u>for this ailment</u> by another healthcare practitioner within <u>the past 4 months ?</u> ❑ No ❑ Yes Who ? _____________ Treatment: _______________
10. Please list any relevant diagnostic tests: ______________________________
11. Employed Status: ❑ Full Time ❑ Part Time ❑ Out of Work ❑ Light Duty ❑ Retired