APPOINTMENT AND CANCELLATION POLICIES

Patients are seen by appointment only and therefore it is advisable for you to schedule the full duration of your referral as far in advance as possible. If you do need to cancel, we ask that you call us before closing hours the day prior to your scheduled appointment. If you need to cancel after hours, please leave a message on our answering machine. Any missed appointments may result in a $50 cancellation/no show fee.

INFORMED CONSENT FOR CARE AND TREATMENT

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to fully cooperate with the evaluation and treatment program. All individuals will be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religious, age, sexual orientation, or sources of payment for care.

Response to physical therapy intervention varies from person to person so it is not possible to predict your response to a specific modality, procedure, or exercise protocol. The Physical Therapy Clinics, Inc. cannot and do not guarantee what your reaction will be to a specific treatment, nor can it guarantee that the treatment will help resolve the condition for which you are seeking treatment. Potential benefits of treatment may include an improvement in my symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in movements and a decrease in pain or discomfort. However, there are potential risks that the physical therapy treatment may cause: you may experience an increase in your current level of pain or discomfort or result in aggravation of existing systems, pain, or injury. It is very important for you to promptly provide any updates about your medical condition(s) and to communicate with your treating physical therapist throughout your treatment.

You may decline any part of your treatment at any time before or during treatment if you feel any discomfort or pain or have any other unresolved concerns. You may ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results, and you may discuss the potential risks and benefits involved in your treatment.

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. You understand that the physical therapist provides a wide range of services and you will receive information at the initial visit concerning the proposed treatment and options available for your condition.

By signing below, I have read the appointment policies and this consent form and understand the risks involved with physical therapy care and treatment. I voluntarily assume all of the foregoing risks and accept full responsibility for any loss, property damage, illness or exposure to illness, or personal injury, including death, that may be sustained by me or my property, as a result of my receiving such physical therapy care and treatment. I hereby give consent for The Physical Therapy Clinics, Inc. to furnish such care and treatment considered necessary and proper in treating my physical condition.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.
Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

All information provided herein is true and correct. I give permission to The Physical Therapy Clinics, Inc. to release/obtain information, verbal and written, contained in my medical record, and other related information, to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. By signing below, I authorize direct payments to The Physical Therapy Clinics, Inc. for services provided.

PAYMENT AGREEMENT

In consideration for the services rendered and to be rendered to the above-named patient by The Physical Therapy Clinics, Inc., I expressly guarantee payment of the account and agree to pay any charges left unpaid in whole or in part by the insurance company. The patient is ultimately responsible for account totals and balances. The information below is provided to you only as a summary of benefits and is not a waiver of your payment guarantee or any explanation of your benefits. Patients must contact their insurance company for full "disclosure" of benefits. Please notify us if at any time there is a change in your insurance eligibility and/or benefits.

Please be advised:

Worker's Compensation patients, the above payment terms do not apply for those patients that are covered under worker's compensation. However, be advised as a worker's compensation patient that you may be held responsible for your charges in the event that your claim is disputed and/or denied.

Medicare patients, you may not access Home Health Agency Benefits and attend our clinics during the same period of time. Due to Medicare requirements, it is your responsibility to see your physician and provide a new referral to our office as required (usually 30 to 60 calendar days). If we do not receive a new referral from your physician as required, Medicare may deny payment of services and you could be financially responsible for therapy provided outside of the referral dates or we may be unable to continue treatment until a new referral is received.

Auto Insurance patients, your insurance does not usually disclose the amount of medical allotment you have and therefore it is your responsibility to keep track of all medical payments from other healthcare providers.

Estimated Insurance Benefits: _____**LIEN AGREEMENT SIGNED BY ATTORNEY**_____

Estimated Patient Payment: _____**NO PAYMENT DUE AT THIS TIME**_____

The patient is to inform us immediately of any changes in representation
Failure to do so will result in the patient becoming responsible for all charges accrued for services

By signing below, I agree to the release of information/assignment of benefits provisions above and these payment terms. I have read and understand that I am ultimately responsible for payment of my account (including any deductible or co-payment amount due at the time of service) and for any and all account balance not paid by my insurance company and that the insurance benefits above are estimates only. After 90 days, any balance not paid by insurance will become my responsibility.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.
Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

Authorization to Utilize Text Messaging, Emailing and Voicemail

Performance Physical Therapy can text message, email or may leave you a voicemail for the purpose of appointment reminders, review requests and/or marketing.

Email: Yes _____ No, thank you _____ Appointment reminder only _____ Initial: _____

Text: Yes _____ No, thank you _____ Appointment reminder only _____ Initial: _____

Cell phone number _____-_____-_____ **Cell phone provider** _____

Voicemail: Yes _____ No, thank you _____ Initial: _____

I give Performance Physical Therapy permission to communicate my appointments and other health concerns to the following individual(s):

1. Name: _____ Phone: ___-___-____
2. Name: _____ Phone: ___-___-____

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.
Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT AND PATIENT CONSENT

I have read and fully understand The Physical Therapy Clinics, Inc.'s Notice of Privacy Practices. I understand The Physical Therapy Clinics, Inc. is permitted by law to use or disclose my personal health information for the purposes of carrying out treatment or payment. I understand that I have the right to request restrictions regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that The Physical Therapy Clinics, Inc. will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in The Physical Therapy Clinics, Inc.'s Notice of Privacy Practices. I understand that I retain the right to revoke this consent by modifying the practice in writing at any time.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.
Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. **If you do not understand a question, leave it blank and your therapist will assist you.** Thank you!

NAME: _____ OCCUPATION: _____

Age:_____ Height:_____ Weight:_____

Leisure Activities: _____

Allergies: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes No List any other allergies we should know about: _____

Are you currently seeing any of the following?

Medical doctor (M.D.)	YES	NO	Psychiatrist/Psychologist	YES	NO
Osteopath (D.O.)	YES	NO	Chiropractor	YES	NO
Physical therapist	YES	NO	Other _____		

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

_____

_____

Have you EVER been diagnosed as having any of the following conditions?

YES	NO	Cancer If YES, describe **WHAT KIND AND WHEN**: _____
YES	NO	Heart problems
YES	NO	Pacemaker/AFIB
YES	NO	High blood pressure
YES	NO	Circulation problems
YES	NO	Asthma
YES	NO	Emphysema
YES	NO	Bronchitis
YES	NO	HIV/AIDS
YES	NO	Chemical dependency (i.e., alcoholism/drugs)
YES	NO	Hypo/Hyper Thyroid
YES	NO	Diabetes
YES	NO	Multiple sclerosis
YES	NO	Osteo (bone) arthritis
YES	NO	Other arthritic conditions
YES	NO	Metal implants
YES	NO	Depression
YES	NO	Hepatitis
YES	NO	Tuberculosis
YES	NO	Stroke
YES	NO	Kidney disease
YES	NO	Anemia
YES	NO	Epilepsy
YES	NO	Other

For Office Use

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

	DATE	REASON FOR SURGERY/HOSPITALIZATION		DATE	REASON FOR SURGERY/HOSPITALIZATION
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

	DATE	INJURY		DATE	INJURY
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____

Has anyone in your immediate family (**parents, brothers, sisters**) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart disease	YES	NO	Anemia
YES	NO	High blood pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Kidney disease	YES	NO	Mental illness
YES	NO	Alcoholism (or other chemical dependency)			

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES	NO	Aspirin
YES	NO	Tylenol
YES	NO	Advil/Motrin/Ibuprofen
YES	NO	Laxatives
YES	NO	Decongestants
YES	NO	Antihistamines
YES	NO	Antacid
YES	NO	Vitamins/mineral supplements
YES	NO	Other _____

For Office Use

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

YES	NO	Weight loss/gain
YES	NO	Nausea/vomiting
YES	NO	Fatigue
YES	NO	Weakness
YES	NO	Fever/chills/sweats
YES	NO	Numbness or tingling
YES	NO	Dizziness / Blurred Vision

For Office Use

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

I certify that all information provided herein is true and correct.

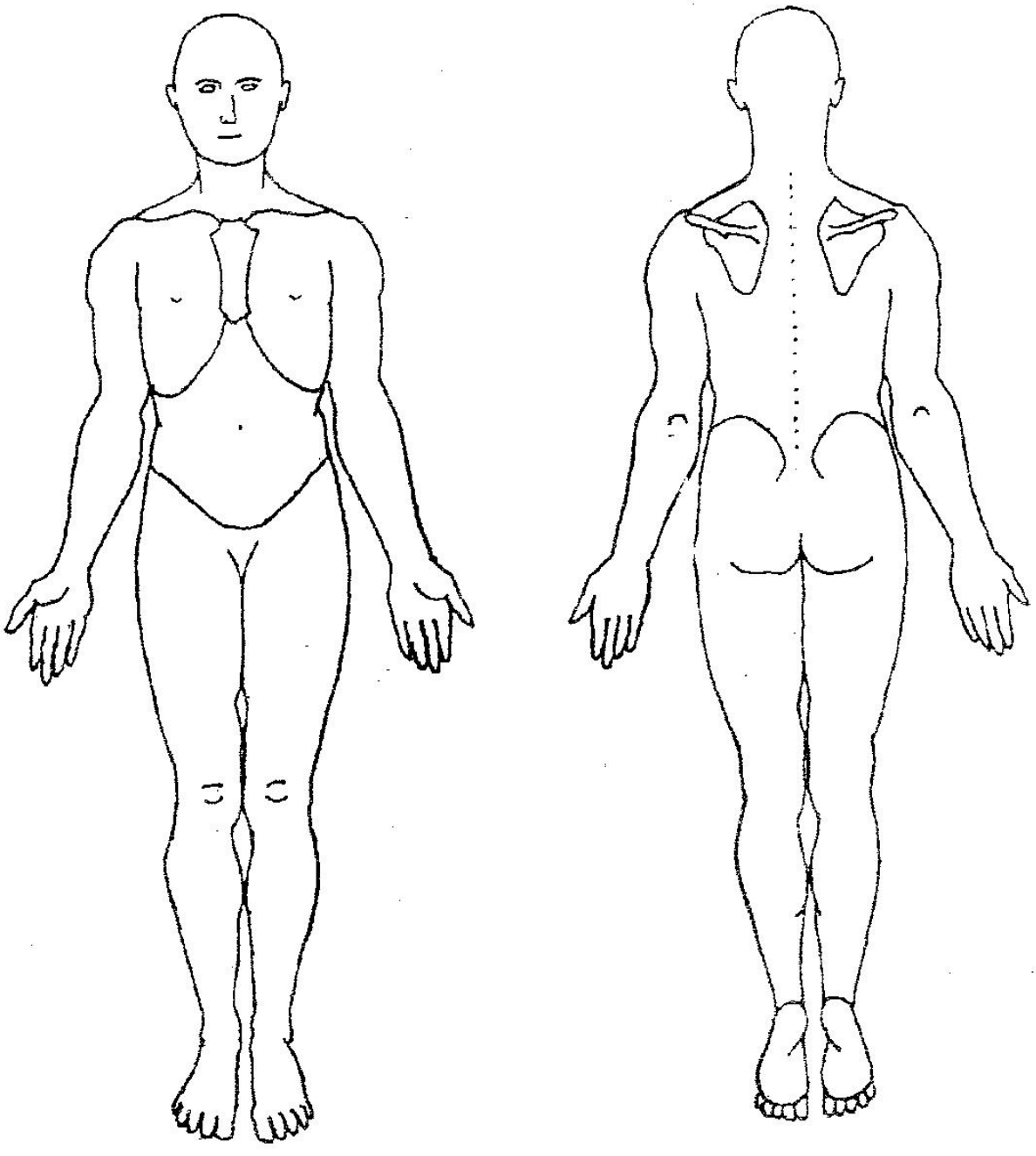
_____**(Patient's Signature or Legal Guardian if under 18)**

_____ _____

Therapist Signature Date

Patient's Symptom Drawing

Please mark an "X" on the body where you feel your pain or problem.
You will speak with your therapist about your symptoms.



Name: _____Date:_____