Pineywoods Physical Therapy

Move Better. Work Better. Play Better. Live Better.

Patient Registration Form

Registration Information:

Date of Birth: _____ Gender: Male ☐ Female ☐ Last 4 SSN:_____

Patient's Name: _____
First Middle Initial Last

Mailing Address: _____ Phone: Home (____)_____
Street Address Cell (____)_____

_____ Email: _____
City State Zip

How would you like to receive appointment reminders? Text Message ☐ Email ☐

If patient is a minor or requires a legal guardian:

Legal Guardian Name: _____
First Middle Initial Last

Address (if different from above): _____ Phone: Home (____)_____
Street Address Cell (____)_____

_____ Email: _____
City State Zip

Relationship to patient: _____

Personal Information:

Occupation: _____ Employer (if applicable):_____

Employer Address: _____ Phone: Work (___)_____
Street Address Ext:_____

_____
City State Zip

Marital Status: Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐

Emergency Contact: _____ Phone: Home (___)_____

Relation: _____ Cell (___)_____

Work (___)_____

Insurance Information:

Cards Provided ☐

Primary Provider: _____ Group #: _____

Address: _____ Member ID: _____
Street Address Policy #: _____

_____ Phone: (___)_____
City State Zip Fax: (___)_____

Consent to Physical Therapy Evaluation and Treatment (Please Read):

1. I hereby consent to the evaluation and/or treatment by the licensed physical therapists employed by or under contract with Pineywoods Physical Therapy for myself, my child, or the person for whom I serve as their legal guardian. I understand, acknowledge, and affirm that such evaluation and/or treatment may involve bodily contact, touching, and/or direct contact of a sensitive nature.

   I further acknowledge that I have received and understood an explanation concerning the nature and process of the procedures, evaluation, and course of treatment; and a Pineywoods Physical Therapy employee and or contract employee has witnessed my signature of this contract in his or her presence. I attest that a licensed physical therapist employed or contracted by Pineywoods Physical Therapy has informed me of some expected health benefits and possible complications and/or discomfort, which may result from skilled physical therapy care. In addition, a licensed physical therapist employed or contracted by Pineywoods Physical Therapy has explained to me the risks of receiving no treatment.

   Furthermore, a licensed physical therapist employed or contracted by Pineywoods Physical Therapy has also explained that there is no guarantee that the proposed course of treatment will improve the condition of myself, my child, or the person for whom I serve as their legal guardian; and that it is possible, though unlikely, that the course of treatment may cause additional pain/discomfort/aggravate the condition of myself, my child, or the person for whom I serve as their legal guardian. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand that it is my right to ask any further questions concerning the care and/or condition of myself, my child, or the person for whom I serve as their legal guardian throughout the time spent under the care of Pineywoods Physical Therapy. I confirm that I have read and fully understand this consent form.

2. I, as parent and/or legal guardian of a patient receiving treatment here at Pineywoods Physical Therapy, do hereby agree and understand that I have been advised to remain on the premises during any such treatment; and waive any claim that I may have resulting from failure to do so.

3. I acknowledge and affirm that Pineywoods Physical Therapy is not responsible for loss or damage to personal valuables.

4. I hereby release, discharge, and acquit Pineywoods Physical Therapy, its agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and/or medical services, including but not limited to ambulance services, emergency medical technician, physician, or urgent care services.

5. I hereby assign all benefits directly to Pineywoods Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the notice of privacy practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive: I will be financially responsible for payment.

I understand that I have the right to refuse to sign this form and would therefore withhold consent for physical therapy ser-

Thank you for choosing us as a provider—Welcome to Pineywoods Physical Therapy!

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____

Patients with Medicare Only:

Have you received Physical Therapy or Speech Therapy services anywhere else this calendar year?

Yes ☐ No ☐

Are you currently receiving any **Home Health Services** (Physical Therapy, Occupational Therapy, Speech Therapy, Nursing, etc.)?

Yes ☐ No ☐

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Acknowledgement of Receipt of Privacy Practices for Protected Health Information

I acknowledge that I have received Pineywoods Physical Therapy, LLC Notice of Privacy Practices for protected health information.

Name of Patient: _____ Date: _____

Signature of Patient: _____ Date: _____

If applicable:

Name of Legal Guardian: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

For Staff Use Only:

Documentation of good faith effort to obtain written acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

_____Showing the patient the Notice of Privacy Practices posted in our office
_____Giving the patient the Notice of Privacy Practices to read prior to receiving any treatment for service.
_____Asking the patient to sign this acknowledgement form.
_____Other (explain)_____

I was unable to obtain the patient's written acknowledgement because (check all that apply):
_____The patient refused to sign this form
_____The patient would not sign the form because the patient said he/she did not understand the notice
_____Other (explain)_____

Signature: _____ Date:_____
Staff Member

Note: This written acknowledgement must be completed no later than the first date of health care services or treatment are provided to the patient after October 1, 2015. This acknowledgement must be retained in the patient's permanent records.

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HIPAA Compliance Patient Consent Form

Our **Notice of Privacy Practices** provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By Signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

★ May we phone, email, or send a text to you to confirm appointments? YES NO

★ May We leave a message on your answering machine at home or on your cell phone? YES NO

★ May we discuss your medical condition with any member of your family? YES NO

★ If YES, please name the members allowed:

This consent was signed by: _____
(PRINTED NAME)

Signature:_____ Date:_____

Witness:_____ Date:_____

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Cancellation/NO SHOW Policy

- Please do not self-discharge. Success in rehab depends upon keeping the prescribed number and frequency of visits and consistent attendance results in the most expedient and best outcome.
- We have intentionally designed our practice to be a low-volume clinic. We want you to get the individualized, HIGH-LEVEL care that you need. Our therapists have appointments back-to-back and we keep a waiting list of clients needing appointments. Late cancellations and no shows hurt the business and prevent others from receiving care.
- We require **24-hour notice** for the cancellation of all scheduled appointments.
- We understand that extenuating circumstances sometimes occur. We will allow two cancellations before charging you a cancellation fee.
- There is a **$30 fee after 2 cancelled sessions without a 24-hour notice.**
- There is a **$40 fee for a NO SHOW** (not showing up for an appointment without any communication).
- Insurance does not cover these fees. They are fully the responsibility of the patient or guardian and apply to ALL patients.
- After two NO SHOW appointments we will remove you from our schedule.

By signing below, I agree that I understand the Pineywoods Physical Therapy Cancellation/No Show Policy and my responsibility to plan my appointments accordingly. I will notify Pineywoods Physical Therapy as soon as possible when I have conflicts with my scheduled appointments, and will pay any fees I incur when I am unable to do so.

Printed Name Signature Date

Physical Therapy Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: _____

Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ Have you ever smoked? _____ How Often? _____

Are you pregnant? _____ Do you have a Pacemaker? _____

Allergies: _____

What medications are you currently using? _____

Previous complaints/surgeries: _____

Previous diagnoses/medications: _____

Complaint

What is your major complaint? _____

Start Date: _____ Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They Are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

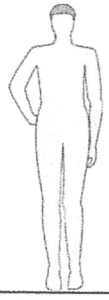
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

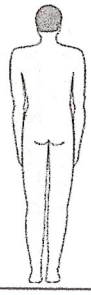
Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort





_____ _____

Signature Date