



Back to Life Physical Therapy, Inc.

PATIENT INFORMATION FORM

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Best number to reach you) _____ (home/work/cell – circle one)

Phone (Alternate) _____ (home/work/cell – circle one)

Email Address _____

Employer _____

Job Title _____

Birth Date _____ Age _____

Emergency Contact Name _____

Emergency Contact Phone _____

Emergency Contact's Relation to You _____

Primary Physician _____

Referring Physician _____

Physician's Diagnosis _____

Brief description of your symptoms _____

Have you had surgery related to the condition for which you are coming to physical therapy? _____

If yes, please list, with dates: _____

Were you injured at work? _____ Date: _____

Were you injured in an Auto Accident? _____ Date: _____

PREVIOUS MEDICAL HISTORY

Please indicate yes if you have now, or have previously had, any of the following:

| | | | |
|---------------------|-------|------------------|-------|
| High blood pressure | _____ | Pregnancies | _____ |
| Low blood pressure | _____ | Depression | _____ |
| Heart disease | _____ | Asthma | _____ |
| Cancer | _____ | Emphysema | _____ |
| Diabetes | _____ | Thyroid disorder | _____ |

Other medical history (please list): _____

Allergies (please list – if any): _____

Surgeries (please list, with dates - even if they seem unrelated): _____

Musculoskeletal injuries/strains other than those for which you are coming to physical therapy
(Please list - even if they seem unrelated): _____

Medications (please list): _____

Have you experienced previously the condition for which you are seeking treatment? _____(yes/no)
If yes, please describe how frequently, whether you have sought treatment, and if so, what type of
treatment. _____

Patient Signature: _____ Date: _____

POLICIES AND CONSENTS

Welcome

Our goal at Back to Life is to provide you with precise, effective and compassionate physical therapy. Please take the time to read the following office policies carefully and to then sign the statements of consent.

Financial Policy

The financial responsibility for services rendered is yours. Payment of charges is due at the time of service.

Appointment Policy

You are responsible for scheduling your appointments.

Appointments are scheduled for one hour each of which 55 minutes is spent one on one in the physical therapy session.

The treatment schedule is booked so that you will not be kept waiting. Failure to arrive at your scheduled appointment time will result in less time available for your treatment.

Appointment cancellations require a minimum of 2 business days' notice. In the case of Monday appointments, please call by Thursday, and for Tuesday appointments, please call by Friday.

You will be responsible for the full payment of a session cancelled without 48 hours notice regardless of the reason for your cancellation.

I have read the above policies and agree to comply with them. I authorize release of any information regarding my treatment in this facility to my referring physician.

Patient Signature: _____

Date: _____

Consent to receive services: I hereby authorize Amy Selinger, DPT, OCS, Jessica Manley, PT, DPT and/or Iris Warchall, PT, DPT to render appropriate physical therapy services to me. I recognize and agree that I have the right to refuse treatment or to terminate treatment at any time by notifying Amy, Jessica and/or Iris. In addition, Amy, Jessica and/or Iris may terminate services by notifying me of the termination and reason.

Authorization for Emergency Medical Services: In the event of a medical emergency during physical therapy treatment, I authorize Amy, Jessica and/or Iris to provide or obtain such medical treatment as they deem advisable under the circumstances and I agree to assume sole responsibility for all charges for such treatment.

Patient Signature: _____

Date: _____

I have received a copy of this policy

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review The Notice before signing this Consent. The terms of The Notice may change. If we change The Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reference to your prior Consent. Back to Life Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Rights

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review The Notice.
- The Practice reserves the right to change The Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of this HIPAA practice notice.

Consent was completed by: _____
Printed Name of Patient or Representative

Relationship to Patient (if other than patient): _____

Witness: _____
Printed Name of Practice Representative