**PATIENT INFORMATION**

Name

Street Address

City State ZIP

Home/Cell Phone Work Phone Email

Date of Birth Age Sex ­­­­­­­­­­­­­­­­­ Marital Status

Emergency Contact/Phone Referral by:

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent for Restore PT to furnish the medical care and treatment considered necessary and proper in assessing or treating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s physical and mental condition.

Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy Statement/Rates**

**Rates:**

First Visit & Evaluation: $150 (60 -75 min. session)

Follow Up Visit: $125 (60 min. session)

Follow Up Visit: $75 (30 min. session)

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient/Guardian/Responsible Party signature |  | Date |
|  |  |  |
|  |  |  |
| Restore PT Representative/Witness |  | Date |

**Patient HIPAA Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
* The day-to-day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing or medical information with the person(s) named here:

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| Patient or Responsible Party Signature: |  | Date: |  |

**PATIENT MEDICAL HISTORY**

Name (Printed): Referring Source:

Date of Injury:

Please enter your: HEIGHT WEIGHT AGE

Are you currently taking any prescriptions or non-prescription medications? YES NO

|  |  |  |
| --- | --- | --- |
|  |  | List Medications |
| [ ] | Anti-inflammatories |  |
| [ ] | Muscle Relaxes |  |
| [ ] | Pain Medications |  |

Have you had any of the following medical or rehabilitative services for this injury/episode?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | YES | | NO |  | YES | | NO | |
| Chiropractor | | \_\_\_ | | \_\_\_ | EMG/NCV | \_\_\_ | | \_\_\_ | |
| Neurologist | | \_\_\_ | | \_\_\_ | Myelogram | \_\_\_ | | \_\_\_ | |
| Orthopedist | | \_\_\_ | | \_\_\_ | Emergency Room Care | \_\_\_ | | \_\_\_ | |
| General Practitioner | | \_\_\_ | | \_\_\_ | CT Scan | \_\_\_ | | \_\_\_ | |
| Occupational Therapy | | \_\_\_ | | \_\_\_ | MRI | \_\_\_ | | \_\_\_ | |
| Physical Therapy | | \_\_\_ | | \_\_\_ | X-Rays | \_\_\_ | | \_\_\_ | |
| OTHER: |  | |  | |  | |  | |  | |

Do you now have or have you ever had ANY of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |
| Asthma, bronchitis, or emphysema | \_\_\_ | \_\_\_ | Severe/frequent headaches | \_\_\_ | \_\_\_ |
| Shortness of breath/chest pain | \_\_\_ | \_\_\_ | Vision/hearing difficulties | \_\_\_ | \_\_\_ |
| Coronary heart disease or angina | \_\_\_ | \_\_\_ | Dizziness or Fainting | \_\_\_ | \_\_\_ |
| Heart attack or surgery | \_\_\_ | \_\_\_ | Weight loss/Energy Loss | \_\_\_ | \_\_\_ |
| Do you have a pacemaker? | \_\_\_ | \_\_\_ | Hernia | \_\_\_ | \_\_\_ |
| High blood pressure | \_\_\_ | \_\_\_ | Allergies | \_\_\_ | \_\_\_ |
| Stroke/ITA | \_\_\_ | \_\_\_ | Any joint/muscle pain | \_\_\_ | \_\_\_ |
| Blood clot/emboli | \_\_\_ | \_\_\_ | Joint Replacement | \_\_\_ | \_\_\_ |
| Epilepsy/seizures | \_\_\_ | \_\_\_ | Shoulder injury/surgery | \_\_\_ | \_\_\_ |
| Anemia | \_\_\_ | \_\_\_ | Elbow/hand injury/surgery | \_\_\_ | \_\_\_ |
| Infectious disease | \_\_\_ | \_\_\_ | Neck/back injury/surgery | \_\_\_ | \_\_\_ |
| Diabetes | \_\_\_ | \_\_\_ | Knee injury/surgery | \_\_\_ | \_\_\_ |
| Cancer or chemotherapy/radiation | \_\_\_ | \_\_\_ | Leg/ankle injury/surgery | \_\_\_ | \_\_\_ |
| Arthritis/swollen joints | \_\_\_ | \_\_\_ | Are you pregnant? | \_\_\_ | \_\_\_ |
| Osteoporosis | \_\_\_ | \_\_\_ | Do you smoke? | \_\_\_ | \_\_\_ |
| Sleeping problems/difficulties | \_\_\_ | \_\_\_ | Difficulty/Frequent urinating | \_\_\_ | \_\_\_ |
| Thyroid Condition | \_\_\_ | \_\_\_ | Night Pain | \_\_\_ | \_\_\_ |

List any other information that would assist us in your care:

Are you aware of your diagnosis? YES NO

Patient or Responsible Party Signature: Date:

*I have reviewed this information with the patient.*

THERAPIST (Printed) Kimberly A. Scales, PT THERAPIST (Signature)