PRINT CLEARLY

Date:____________**Name** (First)___________________(Last)___________________(M.I.) ______

Home Address____

City____State__________ Zip_________________

Home Phone__________________ Work Phone__________________ Other Phone_______________

Social Security_______________________ Birth Date_____________ Age _____Sex: M / F

Drivers Lic #____________________________ Email Address________________________________

Primary Insurance Subscriber (If different from above):

(First) ________________ (Last) __________________

Social Security # ___________________________ Date of Birth _______________________

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Emergency Contact______________________________**Telephone**_________________________

Referring Physician____ Telephone ____________

Address ____________________________________[FOR OFFICE USE:NPI # __________________]

Who may we thank for your referral other than your Doctor?_________________________________

Employer________________________ **Employment** Full / Part-time / Not Working / Retired

Address____Phone_________________

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other__________________Injury Date ________

Lawyer Involved Yes / No Attorney name ____________________________________

Address____ Telephone # ______________________

Patient Signature:____**Date:**___________________

Patient Name______________________ Referring Physician: ______________ Age: ________

Pain/Complaint ______________________________ Date of Injury: ______

If Pregnant, # of Weeks of Gestation:______________

Anticipated or Actual Delivery Date: ______________

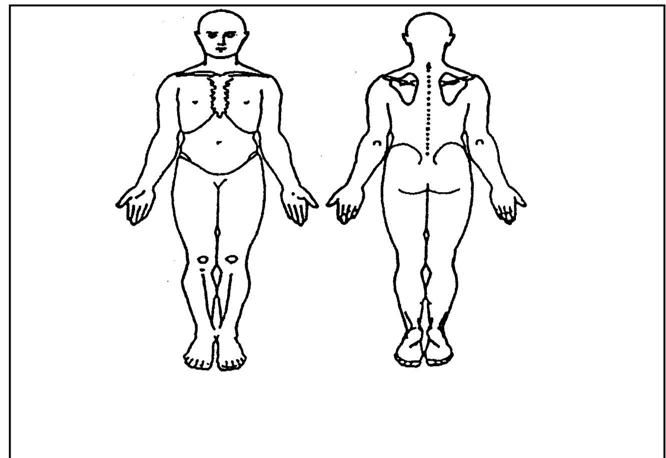
# of Previous Pregnancies: _____# of C-Sections: ______

# of Vaginal Deliveries: _____ # of Episiotomies: ______

Next Doctor's Appointment? ______________

1) Any complications during this or previous pregnancy?
____

2) Complications During labor and delivery?
____



Please mark the area(s) of concern

# of Postpartum Weeks:______ Date of birth of last child:________________

Have you recently noted:

Unusual Weight Loss /Gain
Weakness
Dizziness
Headache
Pain At Night
Abdominal cramps
Naval pain
Low Back Pain
Swelling
Loss of Hair
Persistent Nausea / Vomiting
Fever / Chills / Sweats / Hot Flashes
Numbness/Tingling in hands/fingers or legs
Restless Leg Syndrome
Change in sexual function/pain
Insomnia
Skin Irritation/Itchiness
Cramps in Legs at Night/When Walking
Pain with rolling over in bed/stairs
Fatigue
Hip Pain
Constipation

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

Sprains/Strains, Fractures
Multiple Gestation Pregnancy
Allergies / Skin Sensitivity
Circulation Problems / Clots
Asthma / Breathing Problems
Indigestion / Heartburn
Sexually Transmitted Diseases
Sciatica
Diabetes
Cancer
Bleeding
Fibroids
Fainting
Vaginal Infection/Vaginitis
Placentia Previa
Blood Pressure Problems
Incompetent Cervix
Lung Disease
Urinary Incontinence
Pelvic Pain
Endometriosis
Thyroid Disorder
Cystitis
Heart Problems
Kidney Disease
Bowel Problems

Any previous injury that may affect current care ______________________________

1. **Do you ever experience leakage of**: Urine / Feces / Both / None
2. **Do you have leakage with**:
   Coughing or sneezing? Y / N
   Exercise? Y / N
   Before you can make it to the restroom? Y / N
   Unrelated to any cause? Y / N

Explain & give approximate dates for any items indicated above__________________________

Previous Surgeries:
Hysterectomy: __________ abdominal / vaginal / ovaries removed
Hernia Repair: ___________ C-Section: ______________ Other: __________________

Are you currently taking medications?____

Type Of Symptoms: Sharp / Burning / Aching / Tingling / Numbness / Other ______________
Constant / Intermittent

Rate your symptoms (0= none 10=severe)
At it's worst: 0 1 2 3 4 5 6 7 8 9 10 / At it's best: 0 1 2 3 4 5 6 7 8 9 10

List 3 important activities that you are unable to do or are having difficulty with as a result of your problem. Then rate the activity in difficulty using the following scale:

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform at the same activity level as before injury

1) ____ Rate ________
2) ____ Rate ________
3) ____ Rate ________

Is there anything else you would like to include or ask your physical therapist?
____

____

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? Yes / No
Within the last year, has anyone forced you to have sexual activities? Yes / No

Please rate the following; 0 – no, not at all, 1 – no, not very often, 2 – yes, most of the time, 3 – yes, all of the time:

- I have blamed myself unneccessarily when things go wrong ________
- I have been anxious or worried for no good reason ________
- I have felt scared or panicky for no good reason ________

Patient or Personal Representative Signature **Date**

____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.
For Law Enforcement: We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

X____ **X**____________________

Patient or Personal Representative Signature

Date

- **CONSENT FOR CARE & TREATMENT:** Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Evolution Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.
- **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize **Evolution Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.
- **WORKERS' COMPENSATION CLAIMS:** If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- **CANCELLATION & NO-SHOW POLICY:** We require **24 HOURS** notice in the event of a cancellation. The charge for cancellation without proper notice is **$40** for physical therapy visits and/or the full price of a massage or Pilates visit. This charge will **not** be covered by insurance, but will have to be paid by you personally **PRIOR** to receiving additional treatment. Please enter a valid credit or debit card to be kept on file in the event of a Late Cancel/No Show to pay for your LC/NS fee: *Name on card* ___________________________

CC#____ **Expiration Date** __________

I hereby authorize **Evolution Physical Therapy** charge my credit/debit card to cover acquired Late Cancel or No Show fee. ***X***____

Signature of Card Holder

- **FINANCIAL POLICY:** We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. **Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. In the event that your continued treatment with us exceeds the coverage of your insurance policy, you will be responsible for the full cash payment of services rendered.** We will do everything possible in order to obtain additional visits necessary once insurance coverage ceases (including steps necessary to appeal a denial); however, this does not guarantee that your insurance will accept the request to authorize additional visits. **You are also responsible for keeping track of visits covered in your policy.**

If your insurance authorizes a request for additional visits beyond the initial visits covered in your policy, there will be no change from your financial responsibility outlined in your original policy.

PATIENT RESPONSIBILITY	Co-Insurance
Co-Pay $______________/visit Deductible $______________/year ($__________/MET) ___**Will pay each visit** ___ **Will pay weekly in advance**	Co-Insurance ______________%

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

X____ **X**____________________

PATIENT/Guardian/Responsible Party **Date**

____

Clinic Representative **Date**

IF PATIENT IS A MINOR> PARENTAL CONSENT FOR TREATMENT OF A MINOR**:** As parent and/or legal guardian, I authorize **Evolution Physical Therapy, Inc** to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature ____ **Date**______________