INTUITIVE CHOICE
PHYSICAL THERAPY & WELLNESS

Patient Information

Name: _____
Date: _____
Date of Birth: _____
Address: _____
City: _____State: _____
Occupation: _____Recreation: _____
Home Phone: _____ Cell phone: _____
Email: _____

Emergency Contact Information:
Name: _____
Address: _____
City: _____State: _____
Home Phone: _____ Cell phone: _____

Name of Primary Care Physician and number: _____
Preferred Medical Practice/Hospital _____
Do you have an Advanced Medical Directive you want to place on file? Yes or No

Living Environment:
Stairs with railing ____
Stairs without Railing ____
Ramps ____
Uneven Terrain ____
Elevator ____
Obstacles _____
Assistive Devices: _____

With whom do you live:
Alone ____
Spouse ____
Children ____
Parents ____
Other ____

How did you hear about us? _____

Employment/ Work
Occupation _____
Full Time ____ Part time ____ Other _____

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Medical History:

Cancer	Latex Allergy	High Blood pressure
Diabetes	Allergies	Broken bones
Fibromyalgia	Osteoporosis	Circulation issues
Obesity	Heart Condition	Stomach problems
Arthritis	Thyroid Problem	Surgery for this problem
Depression	Parkinson's Disease	Developmental growth
Stroke	Lung Problems	Multiple sclerosis
Skin Disease	Kidney Problems	

Within the past year have you had any of the following symptoms?

Chest pain	Fever	Loss of balance
Headaches	Dizziness	Joint pain
Bowel problems	Loss of appetite	Coordination problems
Difficulty walking	Weight loss	Weakness in arms and legs
Difficulty sleeping	Weight Gain	Other
Difficulty swallowing	Vision problems	_____
Hearing problems	Urinary problems	
Pain at night	Shortness of breath	

Current Medications:
Name / Dosage / Frequency / Route of administration / Prescribing MD

Name	Dosage	Frequency	Route of administration	Prescribing MD

Have you had any falls in the past year ?
Yes_____ how many _____
No _____

Please list all allergies.
_____

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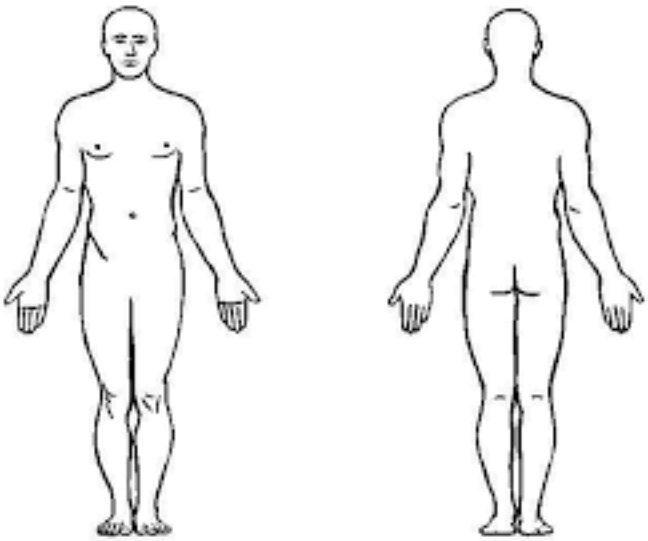
Body Chart

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain.

Stabbing: ///
Burning: XXX
Pins and Needles: 000
Numbness: ---
Aching: ZZZ



Chief Complaints:

When did the problem begin? _____
How you ever had this problem before? _____

What happened? _____

IF yes, How long did the problem last? _____
Did the problem get better? Yes No

What goals do you have for Therapy?

_____

Are you seeing any healthcare providers for your current problem?

_____

Other clinical Tests Performed:

Angiogram	Bone Scan	CT Scan
Stress test	Mammogram	MRI
Nerve conduction study	Electrocardiogram	X-ray

_____

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Consent to Treat

I hear by give consent to Intuitive Choice Physical Therapy to provide the desired services, for it to be physical therapy, wellness, or massage, as requested by myself, or my family member.

I, or my family, have provided full disclosure of any and all relevant past medical history that may impact, influence or contraindicate the prescribed service provided by Intuitive Choice Physical Therapy.

I understand that Intuitive Choice Physical Therapy is fully licensed and its providing therapists are highly trained and skilled. They will ensure the services they provide are safe, appropriate and indicated for my condition. I have a right to know who is responsible for authorizing and performing any and all treatment procedures. Session length is based on client tolerance and the clinician's professional judgment (typical range is 45-55 minutes).

I understand that I will not be subjected to any procedure without my voluntary, competent and understanding consent.

While Intuitive Choice Physical Therapy fully intends to give service that offers no harm, I understand there is always the potential for a risk of injury to occur. Should be the case, I recognize that Intuitive Choice Physical Therapy has taken every necessary precaution to protect me, and therefore, I do not hold Intuitive Choice Physical Therapy liable for any unforeseen injury.
I understand that Intuitive Choice Physical therapy is a private pay company, and not contracted with any insurance companies.

I understand that Intuitive Choice Physical Therapy ensures that information about me and my condition, or reason for receiving services, will remain private and be fully disclosed only upon my approval. I acknowledge & understand my HIPAA policy rights.

_____
Initial

I consent to communicate with Intuitive Choice Physical Therapy and Wellness regarding my care through the following electronic means, Please initial chosen options below to give consent.
_____ Email
_____ Phone Calls
_____ Text Message

I understand that my physical therapist cannot provide an official medical diagnosis but a thorough evaluation of my condition and movement impairments will be performed and relayed to my physician with my consent.
After reading the above, I consent to receive physical therapy at Intuitive Choice Physical Therapy to be terminated when determined by myself, my physician or my Physical Therapist.

_____
Signature

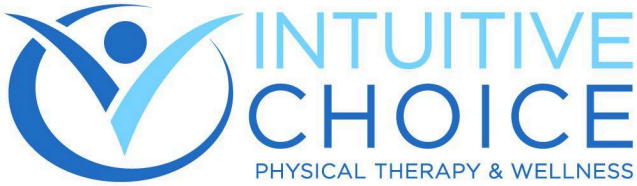
_____
Printed Name

_____
Date

_____
Signature of Family Member

_____
Printed Name

_____
Relationship



Assignment of Benefits Form

Name of Insured: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf for any medical services provided by Intuitive Choice Physical Therapy & Wellness.

I authorize the release of any medical or other information necessary to determine these benefits or benefits payable for related services to Intuitive Choice Physical Therapy & Wellness.

It is my responsibility to notify Intuitive Choice Physical Therapy & Wellness of any change in my health care coverage. I am fully aware that I am responsible for my copays, coinsurance and deductibles at the time of visit.

By signing this form, I understand that I am accepting financial responsibility as explained above for all payments of products or services received.

Explanation of Benefits: _____

Coinsurance: _____

Deductible:_____

Copay:_____

_____ Date _____
Patient Name (Printed)

_____
Relationship to Insured

_____
Signature of Insured/ Parent/Guardian

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form is a "friendly" version of the policy.

What this is all about: Specifically there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with our services. HIPAA provides certain rights and protections to you as the patient. We balance those needs with our goal of providing you the quality professional service and care. Additional information is available from the US. Department of Health and Human Services located at www.hhs.gov.

We have adopted the following:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. You agree to the normal procedures utilized by us to handle your patient record, PHI and other documentation or information.
2. It is the policy to remind patients of their appointments by telephone, text, e-mail and by any means convenient for our practice or requested by you.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to the confidentiality rules of HIPAA.
4. You agree to bring any concerns or complaints regarding privacy to our attention.
5. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the practice concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward.

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Authorization to Disclose Protected Health Information

Name: _____
Date of Birth: _____
Date: _____

I authorize Intuitive Choice Physical Therapy, to discuss my protected health and billing information with my spouse, family members, friends, or physician listed below:

Treating physician: _____ Phone #: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

I authorize the release of pertinent medical records or other information as needed in assistance with any medical claims process, as well as, situations which necessitate communication between Intuitive Choice Physical Therapy and Wellness and other healthcare providers for the purposes of my care. This encompasses all forms of communication including but not limited to written documentation, telephone conversations, facsimile transmissions and email correspondence.

_____ _____
Signature Date

Missed Appointment Policy

Intuitive Choice Physical Therapy and Wellness strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to assure continuity of your treatment. Your consistent participation in the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, last-minute cancellations decrease our ability to accommodate the scheduling needs of other patients.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call us as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is canceled **less than 24 hours** before the appointed time. A no-show is when a patient is not available for an appointment without canceling. In either case, we will charge the patient a fee of $50.

If you arrive more than 15 minutes late for your visit without notifying your therapist, your appointment may need to be modified or canceled and the 24-hour missed appointment policy will apply.

How to Cancel Your Appointment

If you need to cancel or reschedule your appointment, please call/text us at 717-315-8999 (Ashley) or 404-791-0513 (Megan). If necessary, you may leave a detailed voicemail/text message. We will get back to you as soon as possible.

_____
Signature

_____
Printed Name

_____
Date

_____
Signature of Family Member

_____
Printed Name

_____
Relationship