



Demographics

Name _____ DOB _____ Age _____

Address _____

STREET CITY STATE ZIP CODE

Best phone to contact you _____

Permission to receive texts from your physical therapist? (please circle) Yes No

E-mail Address _____

Do you wish to communicate with our office via e-mail? (please circle) Yes No

Emergency Contact

Name _____

Phone # _____ Relationship _____

Referring Physician

Name _____ Date of Injury/Surgery _____

Diagnosis _____

If you were not referred by a physician – how did you hear of us? _____

Primary Physician, if different from referring physician:

Name _____ Phone Number _____

Primary Insurance Company _____

(This is for reference only, as we are out-of-network and don't participate with any insurance providers. You can submit to your insurance based on your personal out-of-network physical therapy benefits)

Employment Status

Occupation _____ Employer _____

Work Status (Circle one):

Full Time Part Time Self Not Working Retired

Common physical positions you go through at work or throughout your normal day (please circle all that apply) :

Sit Stand Walk Sit at Computer Lifting

Other work positions or requirements that affect your physical position: _____

MEDICAL HISTORY

Current Medications: _____ Taking for: _____
_____ Taking for: _____

Past Surgeries/

<u>Significant Health History</u>	Year	Procedure	Successful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Muskulo-Skeletal Injuries/

<u>Significant Health Events</u>	Treatment	Successful?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sports/ Recreation/ Activity History - please describe:

During youth: _____

During college/education: _____

Competitive: _____

Current: _____

Healing Arts Treatment - massage, acupuncture, personal training, etc...

Past Treatment: _____ Successful? _____

_____ Successful? _____

Current Tx: _____ Successful? _____

_____ Successful? _____

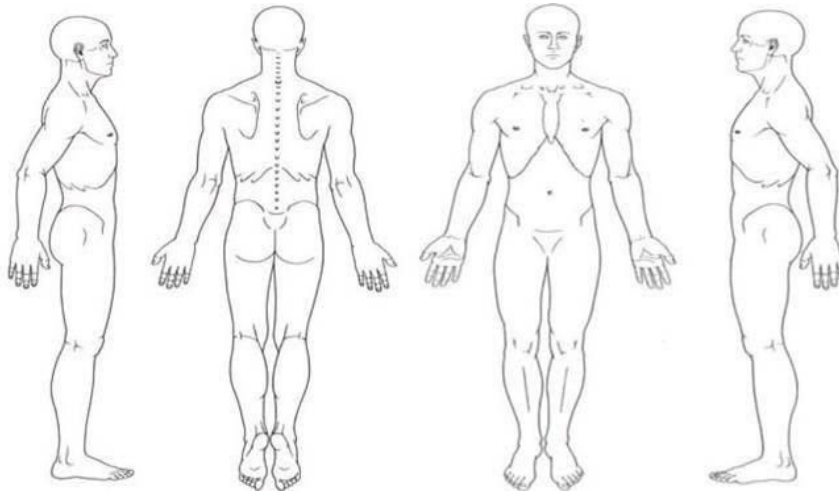
Does your pain vary and change with position changes? YES NO

If yes, describe: _____

What has been most helpful in treating your pain or condition so far?

Symptom and Activity Report

1. Primary Concern for attending Physical Therapy today:
2. Regular exercise engaged in this week:
3. Indicate anywhere on your body with symptoms that would be helpful for your therapist to know about today (ex: aching, numbness, tingling, sharp pain, burning, etc)



4. Level of pain/other symptom (0-10 scale with 10 being the worst):

Physical Goals

1. What do you hope to accomplish through Physical Therapy or movement medicine?
2. Do you have a physical event or a travel date that you are preparing for?
3. Please list anything else you feel the physical therapist should know regarding your injury:

Consent for Treatment

I, the undersigned, do hereby authorize Jennifer Cooper, PT OCS (Licensed Physical Therapist and Certified Orthopedic Specialist) to administer treatment as necessary. I acknowledge that no guarantee or assurance has been, nor can be, made as to the results of the prescribed treatment. Furthermore, I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. Physical therapy involves massage, mobilization, exercise and other modalities to facilitate healing. This involves physical contact with my body, which I consent to. I understand that if I have questions regarding treatment, my home program, or anything in relation to my treatment, I will ask for clarification.

Initials: _____

Cancellation Policy

By signing below, I understand that cancellations **MUST** be made **at least 48 hours, but preferably 72 hours** prior to the scheduled appointment time. I am aware that I will be responsible for a fee that amounts to 100% of the scheduled session cost for no shows or late cancellations within 48 hours of the scheduled appointment time. This payment is due at the time of the originally scheduled appointment. We are a small therapy and wellness practice, and late cancellations do not allow us enough time to schedule another patient. Please be respectful of this policy and do not request for a waiver.

We understand that extenuating cancellation circumstances may occur (such as acute illness), and will be considered on a case-by-case basis. Though our scheduling program is automated to send a reminder email, there can sometimes be a glitch in the system. It is the patient's responsibility to know when the appointment is, to check with reception if confirmation is needed, and to arrive on time. Repeated cancellations and/or no shows may result in discharge from our facility.

Initials: _____

Consent for TeleCommunication during TeleMedicine

I, the undersigned, hereby consent to engaging in telemedicine with Jennifer Cooper, PT OCS RYT as part of my treatment. I understand that "telemedicine" includes the practice of healthcare diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that there are inherent privacy risks from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmissions of my medical information could be disrupted or distorted by technical failures; or that the transmission of my medical information could be interrupted by unauthorized persons, out of control of the provider.

Initials: _____

Notice of Patient Information Practices – HIPAA Compliance

Your personal health information is protected by law and may only be used for personal purposes, auditing purposes, and emergencies. If you provide a written authorization to release your information for any reason, you may later revoke that authorization at any time. You have the right to review or obtain a copy of your health information at any time or request a correction of any inaccurate or incomplete information. If you feel as though your rights to privacy have been violated, you may file a complaint to the US Department of Health and Human Services. Please sign below to indicate that you have read the above information and are aware that your personal health information is protected.

Initials: _____

Payment and Billing policy

Thank you for choosing Flow Physical Therapy. We kindly ask for payment at the time of services, unless other arrangements have been made. We accept cash, check, all major credit cards, Paypal, and Venmo. We can arrange for billing to your accountant or personal assistant if requested. At this time we are **not participating with** any medical insurance providers. This means that our services **may or may not** be covered under the non-provider (out-of-network) policy with your insurance company. It is **your responsibility** to know your policy and your benefits. We will provide records of any service with us, and then you will be able to self-submit according to your plan policy. Self-submission information is usually available online, through the 800 number on your card, or through a human resource department, if available.

Initials: _____

Signature: _____

Date: _____