Cancelation Policy

There is a $25.00 charge for any appointments that are cancelled with less than 24 hours advanced notice.

Signature: ______________________________ Date: ______________

HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature of Patient or Responsible Party: ______________________________

Relationship to Patient: ______________________________ Date: ______________

PATIENT MEDICAL HISTORY

Name: ______________________ Date: __________ Date of injury or surgery: __________

Referring Physician: ______________________ Family Physician: ______________________

Current Medications List: ______________________________

____

Have you ever been to physical therapy before? YES NO

Check the box with your current pain level (*1 least painful — 10 most painful*)

1 2 3 4 5 6 7 8 9 10

Check the box if you have had any of the following Medical or Rehabilitative Services for THIS INJURY/EPISODE? (*Multiple boxes may be checked*)

- Chiropractor
- CT Scan
- EMG/NCV
- General Practitioner
- Massage Therapy
- MRI
- Myelogram
- Neurologist
- Occupational Therapy
- Orthopedist
- Physical Therapy
- Podiatrist
- Emergency Room Care
- X-Rays
- Other: ______________________________

Check the box if you have or ever had any of the following conditions: (*Multiple boxes may be checked*)

- Asthma, Bronchitis
- Severe or frequent headaches
- Angina
- Emphysema
- Shortness of breath/chest pain
- Vision or hearing difficulties
- Coronary Heart Disease
- Numbness or Tingling
- Have a Pacemaker
- Dizziness or fainting
- High Blood Pressure
- Bowel or Bladder Problems
- Heart Attack or Surgery
- Weakness
- Stroke/TIA
- Weight loss/Energy loss
- Congestive Heart Disease
- Hernia
- Blood clot/Emboli
- Varicose Veins
- Epilepsy/Seizures
- Allergie
- Thyroid disease or Goiter
- Any Pins or Metal Implants
- Anemia
- Joint Replacement Surgery
- Infectious Diseases
- Neck Injury/Surgery
- Diabetes
- Shoulder Injury/Surgery
- Cancer or Chemo/Radiation
- Elbow/Hand Injury/Surgery
- Arthritis
- Back Injury/Surgery
- Osteoporosis
- Knee Injury/Surgery
- Gout
- Leg/Ankle/ Foot Injury/Surgery
- Sleeping Problems/Difficulties
- Currently pregnant?
- Emotional/Psychological Dx
- Using Tobacco?

Patient/Guardian Signature: ______________________________ Date: ______________