THE · PT CENTER

PATIENT INFORMATION

First: MI: Last: Gender: Age:

DOB: SS#: Marital Status: Student: ◯ ◯

Legal Guardian or Guarantor Information:

First: MI: Last: Relationship to Patient:

DOB: SS# Gender:

***** If the patient is a minor, enter the address for the legal guardian or guarantor*****

Address: City: State: Zip:

Home Phone | Cell Phone: | Work Phone

School Name (if Student):

Email Address:

Employer Name: Employer Phone:

Employer Address:

Emergency Contact: Phone: Relationship to Patient:

MEDICAL INFORMATION – This section must be completed

Injury Due to (please circle): ☐ Work ☐ Auto ☐ Accident ☐ Surgery ☐ Other ☐ None

Date of Injury/ Surgery/ Symptoms: Body Part:

Height: Weight: Occupation: Current Work Status:

Referring Physician Last Name: First Name: Phone:

Referring Physician Address:

Primary Care Physician: Date of Last Physician Visit:

Have you had other PT, Home Health or Chiropractic visits elsewhere in the current year? YES ◯ No ◯ Where: How many visits:

INSURANCE INFORMATION

Insurance Type – Circle One: ◯ PPO ◯ HMO ◯ POS ◯ MEDICARE ◯ WORK COMP ◯ OTHER

Primary Insurance: Phone:

ID/ Policy/ Claim #: Group #: Relationship to Patient:

Subscriber Name: Subscriber DOB:

Subscriber Employer:

Secondary Insurance:

ID/ Policy/ Claim #: Group #: Relationship to Patient:

Subscriber Name: Subscriber DOB:

Subscriber Employer:

WORK COMP ONLY:

Case Manager: Phone: Fax:

Patient's Chief Complaint (Why patient is seeking physical therapy care):

Briefly describe how your problem began:

What goals would you like to achieve through therapy?

Please Select One Option Below:

- ◯ I am **not** under the care of a medical practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time.
- ◯ I am under the care of a medical practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. **The PT Center for Sports Medicine and Family Physical Therapy** will provide this practitioner with a copy of the initial evaluation within 14 days.

By signing below, you are giving us approval to send a copy of your medical records to your PCP or referring physician.

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

Have any diagnostic tests been performed for this problem? (Check all that apply)

☐ X-rays ☐ Bone Scan/ density ☐ MRI ☐ CT Scan ☐ Other: _____

List body part tested and date tested: _____

Rate your pain or symptom severity on a scale of 0 to 10: No Pain 0 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worse Pain

Have you fallen in the past year? ◯ Yes ◯ No If yes, how many times have you fallen in the past year?

If you have fallen, did it result In an injury? ◯ Yes ◯ No If yes, explain

How would you rate your overall Health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list previous surgeries in the last 5 years with dates:

Please list all medications/ supplements you are taking, including dosage and frequency: (Use additional page if needed)

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Name: _____ Dosage _____ Frequency _____

Please choose Yes or No if you had any of the following conditions:

High Blood Pressure	☐Yes ☐No	Diabetes	☐Yes ☐No	Osteoarthritis	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Pacemaker	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Bowel/ Bladder Dysfunction	☐Yes ☐No	Heart Attack	☐Yes ☐No	Osteoporosis/ Osteopenia	☐Yes ☐No
Acid Reflux/ Ulcers	☐Yes ☐No	Cardiac Bypass	☐Yes ☐No	Scoliosis	☐Yes ☐No
Thyroid Disorder	☐Yes ☐No	Cardiac Stents	☐Yes ☐No	Headaches/ Migraines	☐Yes ☐No
Bleeding Disorder	☐Yes ☐No	Chest Pain	☐Yes ☐No	Dizziness or Fainting	☐Yes ☐No
HIV/ AIDS	☐Yes ☐No	Hepatitis	☐Yes ☐No	Dementia/ Alzheimer's	☐Yes ☐No
Seizures/ Epilepsy	☐Yes ☐No	Parkinson's	☐Yes ☐No	Recent Infection	☐Yes ☐No
Lyme Disease	☐Yes ☐No	COPD/ Asthma	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Congestive Heart Failure	☐Yes ☐No	Emphysema	☐Yes ☐No	Fibromyalgia	☐Yes ☐No
Currently Pregnant # of Weeks _____		Kidney Disease	☐Yes ☐No	Lupus	☐Yes ☐No
Mental Disorder type: _____		Stroke	☐Yes ☐No	Cancer type: _____	

Allergies – list: _____

Please list any disorder not listed above:

WAIVER, RELEASE OF LIABILITY AND INDEMNITY AGREEMENT

I hereby agree to indemnity and safe harmless **The PT Center for Sports Medicine** and defend any action brought against **The PT Center for Sports Medicine** (and its employees, agent, administrators, successors and assigns) with respect to any claim, demand, cause of action, debt, cost, loss, damage and expense (including attorney's fees) to liability that may be sustained or incurred in any manner connected with **The PT Center for Sports Medicine**, its employees, agents, administrators, successors and assigns.

I hereby agree that any disputes arising out of this contract, or my treatment at **The PT Center for Sports Medicine** (and its employees, agents, administrators, successors and assigns) will be resolved through binding arbitration. Should the parties not be able to agree on an independent arbitrator then each side agrees that it will appoint its own arbitrator. The two appointed arbitrators shall then choose a third party arbitrator to preside over the arbitration.

Each party shall be responsible for its share of the arbitration fees. Any party challenging the arbitration clause, or appealing an arbitration award, to Common Pleas Court shall be liable for all attorney fees and costs incurred by the other party.

The releasing party represents that he/ she has authority to enter into this Waiver, Release of Liability and Indemnity Agreement and Agreement to Arbitrate and that he/ she had read and understand the terms and conditions contained herein.

NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review The PT Center for Sports Medicine's Notice of Privacy Practices. I have read and understand the right that I have to protect my healthcare information. This office is committed to maintaining the confidentiality of my healthcare information. I, the undersigned, do hereby agree to give my consent to The PT Center for Sports Medicine to furnish my healthcare information for the purposes of treatment, payment and as otherwise necessary and permitted by law, for healthcare operations. A copy of The PT Center for Sports Medicine's Notice of Privacy Practices will be furnished to me upon request.

To the best of my ability, I have given and included all pertinent information. Signing below indicates agreement to all of the above.

Patient/ Guardian Signature: Date:

RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby agree to give my consent to The PT Center for Sports Medicine to furnish medical care and treatment to above listed patient considered necessary and proper in diagnosis and treating my/ their condition.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, any other health plans, and proceeds from litigation to The PT Center for Sports Medicine. A photocopy of this assignment is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writingIt is our policy to bill your insurance carrier as a courtesy to you. Please remember that insurance is considered a method of reimbursement for service provided to the patient by The PT Center for Sports Medicine and not a substitute for payment. Some companies pay a fixed allowances for certain procedures while others pay a percentage of charges. It is your responsibility to pay any deductible amount, co-insurance and any other balance not paid by your insurance. PAYMENTS FOR YOUR CO-INSURANCE ARE DUE AT THE TIME OF SERVICE. The above does not apply for those patients that are considered Workers' Compensation. However, be advices as a Compensation patient, that you may be held responsible for charges in the event that your claim is denied.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner after such default and upon referral to a collection agency or attorney by The PT Center for Sports Medicine, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. I understand that if no payment is received by The PT Center for Sports Medicine by my account within 90 days, I may be subject to a $3.00/ month accounting fee. This serves as notice that the charge for a returned check for Non-Sufficient Funds is $30.00

The above information has been read and explained to me. I understand my responsibility for payment of my account. . I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/ Guardian Signature: Date:

TREATING ATHLETES

If you are an athlete, by signing below, you give permission for us to send your Plan of Care to the Athletic Trainer at your school if requested.

Patient/ Guardian Signature: Date:

PHOTO & VIDEO RELEASE

I hereby grant The PT Center for Sports Medicine permission to the right of photographs and/or videos of me without payment of any consideration. I understand that my image of video may be edited, copies, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any rights to royalties or other compensation arising or related to use of my image or recording. I understand this permission signifies that photo or video recordings of me may be electronically displayed via the Internet or in public educational settings. I will be consulted about the use of photos or video records for any purpose other than those listed above. By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.

Patient/ Guardian Signature: Date:

INTEGRATIVE DRY NEEDLING CONSENT

Integrative Dry Needling involves placing a small needle into the tissue that it tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system. Like any treatment, there are possible complications. While these complications are rare, they must be considered prior to giving consent to treatment. A detailed Integrative Dry Needling Consent form is available upon request. Should my PT deem Dry Needling beneficial, I my signature represents my consent to the performance of Dry Needling. I can withdraw consent at any time. Do you have any known disease or infection that can be transmitted through bodily fluids: ☐ Yes ☐ No

Patient/ Guardian Signature: Date: