Medically Informed Consent for Treatment

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services with PRISM Physical Therapy, PLLC. It is this clinic's sincere intent to educate me on every process, from the beginning process of filling out paperwork to the expectations upon discharge from physical therapy. Therefore, if certain manual techniques and neuromuscular training exercises are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them. If not clear on understanding or decide not to consent with any aspect of treatment, it is also my responsibility to make this immediately clear to the therapist providing the treatment.

Signature of Parent/Guardian: _____ **Date:** _____

Payment/Billing Policies

PRISM Physical Therapy is a fee-for-service clinic. This means the payment is due at the time services are rendered and your insurance company will NOT be billed. More than likely, we will be an "out of network provider." We can, upon request, provide detailed receipts with diagnosis and treatment codes which you may choose to submit to your insurance company. We accept cash, personal checks, and credit cards.

***Medicare will not pay for services rendered at PRISM Physical Therapy. At this time, we are not a participating provider with Medicare or any other insurance companies. We only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not services covered by Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess. Signing below means that you have received and understand this notice. You may receive a copy upon request at any time.

Given you will be paying at the time of the services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to you personally.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

(If under 18)

Today's Date_____

MEDICAL HISTORY

Patient Name: _____ **Age:** _____ **DOB:** _____/___/_____

I am here today because: _____ **This began:** _____

I am happiest when I participate in these activities:

1. _____ **2.** _____ **3.** _____

What do you want to achieve from your visit(s) at PRISM Physical Therapy?

_____

What is it you want to do but can't do now?

_____

Lumbo / Pelvic / Femoral

Small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise?	Y	N
Pain, discomfort, pressure in pelvic area when sitting/ standing for long periods of time?	Y	N
Do you frequently strain to have a bowel movement or to empty your bladder?	Y	N

Breathing

Do you snore?	Y	N
Difficulty breathing with simple activity?	Y	N
Do you have asthma?	Y	N
Do you use an inhaler?	Y	N
Diagnosed with sleep apnea?	Y	N
Allergies (list if any)_____	Y	N

Feet

Do you have flat feet?	Y	N
Do you have orthotics?	Y	N
Do you have heel lifts or inserts?	Y	N
Pain in the bottom of your feet when standing for long periods?	Y	N

General Health

Cancer?	Y	N
Diabetes?	Y	N
High Blood Pressure?	Y	N
Head Trauma?	Y	N
Liver Disease?	Y	N
Pregnant (currently)?	Y	N
Thyroid Problems?	Y	N
Heart Disease?	Y	N
Chest Pain?	Y	N

List any other medical history necessary to help guide your care

_____

Please list any surgeries you have had (include date):

_____

Please list all medications (current and recent):

_____

Recent imaging (MRI's, x-ray, etc):

_____

I have completed this questionnaire fully to my knowledge of my current health

Signature: _____ Date: _____

Signature of Guardian: _____ Date: _____
(if patient is under 18)

PATIENT CONTACT FORM

Patient's Name: _____ **Today's Date:** _____
First Last

Guardian Name: _____
(if Child) First Last

Address: _____
Street City State Zip

DOB: _____ **Gender:** _____ **Marital Status:** _____

Phone: _____ _____ _____
Home Cell Work

Email: _____

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

I have completed the information sheet and attest the information above is accurate.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Cancellation Policy

_____
Initials

I understand that a $40.00 fee will be charged for a no-show or cancelled appointment without 24 hrs notice. The fee will be added to my account and will be payable at my next scheduled visit. This fee is not reimbursed by your insurance carrier

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information.
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization.

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations, and other oversight activities
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas & as otherwise required by law

Patient Rights

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information
- To receive notices of our privacy practices.

Acknowledgement of Receipt of Notice from PRISM Physical Therapy, PLLC

I hereby acknowledge that I have reviewed the Summary of this medical practice's Notice of Privacy Practices and am aware that I may view a more detailed Notice of Privacy Practices.

Signed: _____ **Date:** _____

Print Name: _____ **Relationship:** **SELF** **PARENT** **GUARDIAN**