Carolina WOMEN'S PHYSICAL THERAPY and WELLNESS

Patient Information

Please fill out completely so that we may serve you better. **Today's Date _____**

Full Name: _____
Last **First** **Middle** **Suffix** **Nickname**

Address: _____
Street Address or Box **City** **State** **Zip**

Phone: _____
Home **Work** **Cell** **Pager**

(Please include area code. Please indicate best number to reach you during business hours with an *.)

Email: _____
May we email you appointment reminders? □ Yes □ No

Additional: _____
Date of Birth Age **If student, please give school**

□ Single □ Married □ Divorced □ Separated □ Widowed

Employment: □ Yes □ No _____
Please list Employer, Occupation/Position

Emergency Contact:_____
(Please provide name and daytime phone number.)

If patient is a minor:

_____
Parent or Guardian's name **SS# of parent** **Parent's phone number**

_____
Parent's Employer **Parent's Employer Address**

Parent's consent for treatment? □ Yes □ No

_____ **Parent's Signature**

INJURY/MEDICAL HISTORY

Location of problem: □ Neck □ Shoulder □ Back □ Pelvic Floor □ Hip/Knee □ Ankle □ Other
Problem Area(s) (Please be specific): _____
_____
Is your treatment here a result of an injury? □ Yes □ No **If yes, date of injury:** _____
Mo/Day/Year

Type of Injury: □ Work □ Auto □ Other
Describe how your injury occurred: _____

Referring Physician: _____
(Name, address, phone number)
Have you had any surgery for *this* condition? □ Yes □ No **Date of Surgery:**_____

Please list ALL medications you are currently taking:

_____

_____

_____

Do you have any of the medical problems listed below? (Please circle all that apply.)

Diabetes Seizures Cancer High Blood Pressure High Cholesterol COPD CHF
Other_____

How did you hear about us? □Yellow Pages □Internet/Web Page □Other _____
_____

INSURANCE/PAYMENT INFORMATION

Do you plan to file Worker's Compensation? □ Yes □ No
If yes, who should we call to verify compensation? _____
Person to verify and phone number (with area code).

Insurance Company – Primary:

_____
Name of Company Group Number Policy Number

_____
Address (Street or Box) City State Zip

_____
Name of Insured Birth date of Insured SS# of Insured Relationship to Insured

Does your primary insurance company require pre-certification? □ Yes □ No □ Unknown

---

Insurance Company – Secondary:

_____
Name of Company Group Number Policy Number

_____
Name of Insured Birth date of Insured SS# of Insured Relationship to Insured

Does your secondary insurance company require pre-certification? □ Yes □ No □ Unknown

---

Carolina
WOMEN'S PHYSICAL THERAPY and WELLNESS

Name:

Age:

1.) What are your <u>main</u> complaints today? Please be specific.

For example: I am having severe low back pain. It started after I helped my sister lift a couch. I haven't been able to lift my child into the car or walk for exercise because of the pain.

2.) How long have you had these symptoms?

For example: This has been going on for 3 weeks.

3.) Have you had any surgeries or previous injuries related to this condition? Please provide the type of surgery and date(s).

For example: I injured my back last year while mowing the lawn. I had back surgery 3 years ago (discectomy).

4.) What makes your symptoms worse?

For example: It is worse when I sit down for longer than 5 min.

5.) What makes your symptoms better?

For example: It feels better when I stand, ice it, or get a massage.

6.) What are your goals for therapy?

For example: I need to be able to sit for at least 30 min without pain. I need to be able to lift my toddler into the car without difficulty. I'd like to get back to my walking program of 1-2 miles twice a week.

Carolina Women's Physical Therapy and Wellness Informed Consent

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Carolina Women's Physical Therapy and Wellness having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Carolina Women's Physical Therapy and Wellness.

I understand that I have the right to ask questions and discuss to my satisfaction with Carolina Women's Physical Therapy and Wellness:

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Physical Therapy evaluation and treatment may include, but are not limited to:

- Physical Exam: general, musculoskeletal, orthopedic and neurological assessments)
- Self Care Techniques: explanation of rehab diagnosis, concepts of exercise/aerobic programs, stress management, postural education, ergonomics, body mechanics, functional balance strategies, home program, pacing, ice/heat, sleep strategies, equipment use, and skin care.
- Therapeutic Exercise: strengthening, stretching, stabilization, resistance training, and aerobic training.
- Neuromuscular Re-education: restoring normal motor firing patterns, proper isolation of muscle contractions, inhibition of over active muscle groups.
- Functional Therapeutic Activities: gait training, balance training, stair training, equipment/device training
- Manual Therapy: soft tissue mobilization, deep tissue mobilization, muscle energy technique, joint mobilizations to spine and joints, pregnancy massage (to relieve muscular discomfort associated with pregnancy), strain/counter strain technique, functional indirect technique and cranio-sacral therapy)
- Pelvic floor treatment: internal evaluation, neuromuscular re-education, biofeedback, electrical stimulation, internal tissue mobilization, bladder and bowel training, urge control techniques, frequency reduction training.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider of these conditions during the evaluation.

I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient	Signature of Patient	Date

Patient Authorization Record

	Authorization for Treatment ➢➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by South Carolina Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authori zation for Release of Information ➢➢ I agree that Carolina Women's Physical Therapy and Wellness may provide information from my medical record to persons involved in my medical care. ➢➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Carolina Women's Physical Therapy and Wellness for services rendered. ➢➢ I agree that Carolina Women's Physical Therapy and Wellness may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢➢ I authorize that direct payment of any benefits available to me be released to Carolina Women's Physical Therapy and Wellness for services rendered.
	Patient Agreement ➢➢ I agree to pay Carolina Women's Physical Therapy and Wellness charges for services rendered to me during my course of treatment. ➢➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Carolina Women's Physical Therapy and Wellness collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢➢ I agree that the information given to Carolina Women's Physical Therapy and Wellness in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Carolina Women's Physical Therapy and Wellness may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢➢ I agree that the information given to in applying for benefits under Workers Compensation is complete and accurate. I agree that Carolina Women's Physical Therapy may give intermediary's information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name Date

_____

Signature of Legal Representative/POA

Carolina Women's Physical Therapy and Wellness Cancellation and No Show Policy

You are coming to therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments.

ALL missed appointments MUST be made up the same week so you may fully recover.

Carolina Women's Physical Therapy and Wellness requires 24-hour advance notice for any cancellation. If you are unable to give 24-hour advance notice or you do not show for your scheduled appointment an administrative fee of $50. This fee MUST be paid prior to your next treatment/session.

Patients who have cancelled or do not show for 3 consecutive appointments or a total of 4 visits in a 3-week period can be immediately discharged due to non-compliance at the therapist's discretion.

I, _____, have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____
Print patient name

_____ _____
Patient signature Date

Carolina Women's Physical Therapy and Wellness

HIPAA Notification

Health Insurance Portability and Accountability Act

Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice. If you would like detailed information regarding how we may use and disclose medical information about you and your individual rights regarding your medical information, please let us know and you will be provided with a copy of our Privacy Practices.

Patient Statement

I am aware that this practice, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the Notice. I may revoke this authorization at any time in writing.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____