



### 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

\_\_\_\_\_  
Signature Parent's

### 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: \_\_\_\_\_





**Name:**

**Age:**

**1.) What are your main 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.

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Printed Name of Patient

Signature of Patient

Date



**Patient Authorization Record**

	<p><u>Authorization for Treatment</u></p> <ul style="list-style-type: none"> <li>➤➤ 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.</li> </ul>
	<p><u>Authorization for Release of Information</u></p> <ul style="list-style-type: none"> <li>➤➤ I agree that Carolina Women's Physical Therapy and Wellness may provide information from my medical record to persons involved in my medical care.</li> <li>➤➤ 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.</li> <li>➤➤ 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.</li> <li>➤➤ I have read "Notice of Privacy Practices" mandated by HIPAA.</li> </ul>
	<p><u>Authorization for Release of Payment</u></p> <ul style="list-style-type: none"> <li>➤➤ I authorize that direct payment of any benefits available to me be released to Carolina Women's Physical Therapy and Wellness for services rendered.</li> </ul>
	<p><u>Patient Agreement</u></p> <ul style="list-style-type: none"> <li>➤➤ I agree to pay Carolina Women's Physical Therapy and Wellness charges for services rendered to me during my course of treatment.</li> <li>➤➤ 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.</li> </ul>
	<p><u>Medicare, Medicaid, and Similar Benefits</u></p> <ul style="list-style-type: none"> <li>➤➤ 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.</li> </ul>
	<p><u>Workers Compensation</u></p> <ul style="list-style-type: none"> <li>➤➤ 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.</li> </ul>

\_\_\_\_\_  
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 a 24-hour advance notice for any cancellation. If you are unable to give a 24-hour advance notice or you do not show for your scheduled appointment a cancellation fee of \$50 will be charged. This fee MUST be paid prior to your next treatment/session.

Patients that are more than 15 minutes late are considered a NO SHOW and charged a \$50 cancellation fee. Patients that are chronically late are at risk for discharge.

**Patients who have canceled or do not show for 3 consecutive appointments or a total of 4 visits in a Physical Therapy Plan of Care may 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: \_\_\_\_\_