PATIENT INFORMATION

PLEASE PRINT

NAME____ DATE OF BIRTH_________________AGE________

NAME OF PARENT/GUARDIAN IF MINOR____

ADDRESS_______________________________________CITY_______________ST______ZIP_____________

CELL#(______)__________________ HM#(______)___________________ WK#(______)_____________________
****MAY WE LEAVE MESSAGES AT THESE NUMBERS?** Y N - CL HM WK**

MAY WE CONTACT YOU VIA EMAIL? Y N EMAIL____

EMERGENCY CONTACT____________________________________ PHONE#(______)____________________

REFERRAL____

PHONE#(______)___________________________ FAX#(_____)_____________________________

FINANCIAL AND INSURANCE RESPONSIBILITIES

We have elected to no longer be a preferred provider for insurance companies. Instead, we provide physical therapy on a **"pay at time of service"** basis. By removing ourselves from contracted status with insurance companies, we do not have to limit the time or quality of treatment we provide because of insurance company restrictions or elevate our rates to pay for billing services.

We recommend you call your insurance company to completely understand your physical therapy benefits.

At the time of service and payment, you will receive a printed statement which you can submit to your insurance company for their consideration of reimbursement to you. We will provide chart notes or other documentation for you or your insurance company's written request. We cannot make guarantees or estimates regarding what reimbursement your plan allows.

I agree to pay DPT for my treatments at time of service, by cash, check, or debit, Visa, Master Card or Discover.
__________(Initial)

CANCELLATION POLICY

I understand if I cancel more than 24 hours in advance, I will not be charged a cancellation fee. I understand if I cancel less than 24 hours in advance, I will pay a cancellation fee of $75.00. ________(Initial)

By signing this document I agree to the conditions stated in this form:

Patient/Guardian Signature____Date______________________

CONDITIONS & CONSENT FOR PHYSICAL THERAPY AT DESERT PT

COOPERATION WITH TREATMENT

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. ___________**(Initial)**

NO WARRANTY

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist can share with me opinions and available statistics and studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.
__________ **(Initial)**

INFORMED CONSENT FOR TREATMENT

The term "**informed consent"** means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services. I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I understand that I can decline any portion of the evaluation or treatment at any time. _________ **(Initial)**

Please initial one below:

_______I would like a witness in the room for physical therapy evaluation and/or treatment.
_______I do not need a witness

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition.
Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You will have greater knowledge about managing your condition and the resources available to you.
Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician. __________ **(Initial)**

I have read the above information and I consent to physical therapy evaluation and treatment. I understand the risks, benefits, and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

____ __________/___________/____________

Patient/Guardian Signature **Date**

****FOR THERAPIST USE ONLY*****

Consent to evaluation/treatment was verbally discussed with patient.

____ _______/_________/__________

Therapist Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

PATIENT NAME:____________________________________DOB:______________

Notice of Privacy Practices

The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that if I have questions or complaints regarding my privacy rights I may contact the person below.

I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices. *I can obtain this practice's current Notice of Privacy Practices online or at the clinic upon request*.

____ _____________________

PATIENT/GUARDIAN SIGNATURE ***DATE***

____Patient refused to Sign

____Patient was unable to sign because___________________________________

Contact Person: Haley Lovich, PT, DPT – (602) 264-3369

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