INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At FORM Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy modality or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care and I wish to proceed. I authorize the release of my medical information to appropriate third parties such as my referring physician and insurance company if I wish to use my insurance.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for FORM PHYSICAL THERAPY, LLC (see last pages of packet). I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to FORM PHYSICAL THERAPY, LLC to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature

Commercial Insurance and Medicare
Payment Authorization and Financial Policies

Please read and initial each statement below:

Assignment of Insurance Benefits: I authorize that the payment of my insurance benefits be made directly to FORM PHYSICAL THERAPY, LLC for any services that are reimbursable by Medicare or any other insurance company. **Initials:** _____

Benefit Verification and Financial Responsibility in Case of Denial: I understand that the insurance benefit information provided to me by Form Physical therapy is ONLY verification of an active policy and NOT a guarantee that my insurance will pay for my physical therapy services. If my insurance company denies payment for services rendered, I agree to financial responsibility. I have been notified by Form Physical Therapy via email of my insurance benefits and wish to proceed. **Initials:** _____

Guarantee of Payment: I understand that all payments designated as 'the patient's responsibility' such as co-insurances, deductibles and copays are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date. **Initials:** _____

Billing: I agree to receive billing statements electronically via square. I understand these statements will contain details on my dates of service of physical therapy and financial responsibility. I understand that Square meets Level 1 PCI Data Security Standards and my credit card data will be encrypted. If I choose to pay by credit card in the office, I understand my card number, magnetic stripe data, and security codes are not stored on Square on Form Physical Therapy's devices. I understand I can choose to pay by cash or check for my services and/or opt out of electronic billing. **Initials:** _____

Cancellation Policy: 'We require 24 hours notice of the need to cancel or reschedule an appointment. **A $35 fee will be charged** for failure to give notice for a missed appointment or for failure to attend a scheduled appointment. If you have an emergency circumstance requiring you to miss an appointment with less than 24 hours notice please email us at info@myformpt.com to discuss the waiver of this fee. **Please note: the automated text reminders sent for your appointment cannot be replied to.** Please call or text us at (586) 330-0499 to cancel or reschedule."
I understand the cancellation policy and agree to pay for any cancellation/no-show fees: **Initials:** _____

Attendance Policy: If 2 consecutive appointments have been missed without notice I understand Form Physical therapy will remove me from the schedule and all subsequent appointments will be cancelled.
Initials: _____

Communication via Text Messaging: Text messaging is a convenient way for patients and Form Physical Therapy to communicate regarding schedule changes, questions or other matters. I understand text message is not a secure form of communication and agree to receive communicate via text with Form Physical Therapy, and I acknowledge if I choose to text personal health information that this information may not be secure and agree to hold Form Physical Therapy harmless in case of breech. **Initials:** _____

I (**print name)** _____ have read, understand and agree to all of the above policies

Signature:_____**Date**:_____
(Guardian's signature if patient is under 18)

PATIENT INFORMATION
Self pay, Medicare and Commercial insurances

(1) Patient Name: (Full Legal Name or as on Insurance Card)

_____

Name: Last First Initial

Birthdate: ____/____/_____

_____

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____
Mobile Home (if applicable)

Emergency Contact: _____ Relationship: _____

Emergency Contact phone: (_____) _____-_____

(2) Condition to be treated in Physical Therapy: _____

Date condition began? Date: ____/____/_____

Is it related to an auto accident? No Yes Date of accident____/____/_____

Is it a non-work related accident? No Yes Date of accident ____/____/_____

Did this condition result in surgery? No Yes If Yes, date of surgery ____/____/_____

Have you had PT services year?
(for this or any condition) No Yes If yes how many sessions _____

Have you had chiropractic services this year?
(for this or any condition) No Yes If yes how many sessions _____

(3) Please list your referring doctor or name of your primary care physician

Doctor Name _____

Doctor Name _____

PATIENT INFORMATION (2)
Medicare and Commercial Insurances

(4) Primary Insurance Information : Check A or B

A. ____ Patient is the insured **(Do not need to complete the rest of #4)**

B. ____ Insured is ___Spouse ____Parent

_____

Name: Last First Initial Sr./Jr.

_____

Address (street) if different than patient City State Zip Code

Date of Birth of Insured: _____/_____/_____

Phone Number of insured:_____

(5) Payer Information:

Primary Insurance Company:

Ins. Co. Name: _____

Patient ID #: _____Group. # _____

Policy/Plan # (if applicable): _____

Customer or provider services phone number on back of card:_____

Secondary Insurance Company: Primary Insured is: _____Patient _____Spouse _____Parent

Ins. Co. Name: _____

Patient ID #: _____Group. # _____

Policy/Plan # (if applicable): _____

Customer or provider services phone number on back of card:_____

Name and DOB of primary policy holder if not patient:_____

Medical History Form

Name:_____ **Date:** _____

Date of Birth: _____

Sex assigned at birth: M/ F/ X **Gender Identity:** _____

What brings you in to physical therapy?

What are the top 3 activities that are the most difficult for you because of this condition?

1._____
2._____
3._____

General Medical History: Please check all that apply

____Diabetes	____Respiratory Issues	___Depression
____Heart Problems	____High Blood Pressure	___Anxiety
____Urinary Tract Infection	____Gastrointestinal Disorders	___Cancer
____Autoimmune Disorder	____Musculoskeletal Problems	___Stroke

____OTHER:_____
_____
_____

Please list past injuries:

_____
_____
_____

Please list all past surgeries with date of surgery:

_____
_____
_____

Please list all medications, herbal supplements and over the counter medications you are currently taking and doses (or provide list)

_____
_____
_____

Are you allergic to Latex? Y / N **Any additional Allergies?**_____