



Name _____ DOB _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address _____ Preferred Appointment Reminders Text Email

In Case of Emergency _____ Phone _____

Informed Consent for Treatment

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Payment

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service. We accept Visa, MasterCard, American Express, cash and checks.

Insurance

We are out of network with all insurance companies. As a courtesy we will prepare and send the claim for you in an unassigned basis. This means the insurer will send the payment directly to you. I understand that my insurance forms will be submitted electronically/mailed from 5 Point Physical Therapy PLLC so that I may get reimbursed. It is my responsibility to follow up on my reimbursements with my insurance company.

Not all insurance plans cover all services. In the event your insurance plan determines a service “not to be covered,” you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior-authorizations. It is the patients’ responsibility to know their physical therapy benefits, check with their insurer if the prior-authorization is required and to follow up with our office if it was obtained & visits were approved.

Privacy Notice

5 Point Physical Therapy PLLC maintains the privacy of patient health information. I am aware that a Notice of Privacy Policies is available in the waiting room and that I may ask our office staff or your Physical Therapist for a copy of the notice to take home with me.

I authorize the release of any medical information necessary to process the claim for services rendered to me.

I HAVE READ AND UNDERSTOOD 5 POINT PHYSICAL THERAPY PLLC FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient /Guardian Signature _____

Date: _____



CANCELLATION POLICY

Name _____

Cancellation/No Show/Late Policy:

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

Cancellations

Our practice requires that if you have to cancel, it must be before 12pm on the previous BUSINESS DAY prior to your appointment, otherwise, you will be charged \$125.00. If your appointment is on a Monday, please notify our office by noon on the previous business day.

No-shows

Anyone who either forgets or consciously chooses to forgo his or her appointment for whatever reason will be considered a "no-show". **They will be charged for the "full" session** and future service will be denied until payment is made.

Arriving late

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session.**

When you do not keep a scheduled appointment 3 people are hurt:

YOU-Because you are not getting the treatment you need.

THE THERAPIST-Who has an open space in the schedule, which was reserved exclusively for you.

ANOTHER PATIENT-That could have been scheduled if you would have given our office proper notice.

I have read and understood 5 Point Physical Therapy PLLC cancellation policies and I agree to be bound by its terms.

Patient /Guardian Signature _____

Date: _____



Privacy/Information Exchange

Email Authorization

5 Point Physical Therapy is equipped to relay information to you using email. Due to the “HIPPA Notice of Privacy Practices” we need your permission to communicate with you electronically. Please note, although every effort is made to ensure patient privacy, 5 Point cannot assure confidentiality of information sent electronically. 5 Point cannot be held liable for security risks.

By signing below you grant permission for practitioners and staff of 5 Point to contact you via email to discuss your care.

Patient Name: _____

Patient DOB: ____/____/____

Patient Signature: _____

Patient Personal Email: _____

5 Point will also use this means to send you periodic updates about activities at our office. These might include changes in policies, new service offerings, newsworthy health research findings, our 5 Point newsletter, special offers and invitations to events.

PLEASE NOTE: We will never share your email address with anyone.



Health History

Name _____

1. Describe the current problem that brought you here? _____

2. When did your problem first begin? ___ months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst. _____
Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

6. Describe previous treatment/exercises _____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (ie. - sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers -running water/key in door
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves your symptoms? _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst ___

11. What are your treatment goals/concerns? _____



Pg 2 History

Name _____

Health History: Date of Last Physical Exam _____ Tests performed _____

General Health: Excellent Good Average Fair Poor Occupation _____
 Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Mental Health: Current level of stress High ___ Med ___ Low ___ Current psych therapy? Y/N

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
 Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

- | | | |
|----------------------------|--------------------------|---------------------------------|
| Cancer | Stroke | Emphysema/chronic bronchitis |
| Heart problems | Epilepsy/seizures | Asthma |
| High Blood Pressure | Multiple sclerosis | Allergies-list below |
| Ankle swelling | Head Injury | Latex sensitivity |
| Anemia | Osteoporosis | Hypothyroid/ Hyperthyroid |
| Low back pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac/Tailbone pain | Fibromyalgia | Diabetes |
| Alcoholism/Drug problem | Arthritic conditions | Kidney disease |
| Childhood bladder problems | Stress fracture | Irritable Bowel Syndrome |
| Depression | Rheumatoid Arthritis | Hepatitis HIV/AIDS |
| Anorexia/bulimia | Joint Replacement | Sexually transmitted disease |
| Smoking history | Bone Fracture | Physical or Sexual abuse |
| Vision/eye problems | Sports Injuries | Raynaud's (cold hands and feet) |
| Hearing loss/problems | TMJ/ neck pain | Pelvic pain |
| Other/Describe _____ | | |

Surgical /Procedure History

- | | | | |
|----------------------|--------------------------------|-----|-----------------------------------|
| Y/N | Surgery for your back/spine | Y/N | Surgery for your bladder/prostate |
| Y/N | Surgery for your brain | Y/N | Surgery for your bones/joints |
| Y/N | Surgery for your female organs | Y/N | Surgery for your abdominal organs |
| Other/describe _____ | | | |

Ob/Gyn History (females only)

- | | | | |
|-----|---------------------------------------|-----|-----------------------------|
| Y/N | Childbirth vaginal deliveries # _____ | Y/N | Vaginal dryness |
| Y/N | Episiotomy # _____ | Y/N | Painful periods |
| Y/N | C-Section # _____ | Y/N | Menopause - when? _____ |
| Y/N | Difficult childbirth # _____ | Y/N | Painful vaginal penetration |
| Y/N | Prolapse or organ falling out | Y/N | Pelvic pain |
| Y/N | Other /describe _____ | | |

Males only

- | | | | |
|-----|-----------------------|-----|----------------------|
| Y/N | Prostate disorders | Y/N | Erectile dysfunction |
| Y/N | Shy bladder | Y/N | Painful ejaculation |
| Y/N | Pelvic pain | | |
| Y/N | Other /describe _____ | | |

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____