Name _____ **DOB**_____ **Date**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Appointment Reminder: Text_____ **Voice message** _____ **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 if you have to cancel, it must be before 12pm on the BUSINESS DAY prior to your appointment. Any cancellations after 12pm the business day prior will result in a $125.00 late cancel fee. If your appointment is on a Monday, you must notify our office by noon on the previous Friday.

We do offer confirmation texts, calls, and emails. If you are not signed up for this or have not been receiving this please let our front desk staff know.

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 out 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

___ Sitting greater than_____ minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

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_____		

Medications - pills, injection, patch Start date Reason for taking

_____

_____

_____

_____

Over the counter -vitamins etc Start date Reason for taking_____

_____

_____