PURE REHAB
PHYSICAL THERAPY

CONSENT TO ROUTINE PROCEDURES & TREATMENTS & FINANCIAL RESPONSIBILITY

CONSENT TO ROUTINE PROCESURES AND TREATMENTS:

I consent to routine procedures and treatments at Pure Rehab Physical Therapy. I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with Pure Rehab Physical Therapy) at any time. I understand the practice of physical therapy is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks. I understand that no guarantees can be made as to the outcome of my care.

Financial Consent:

I assign any right I may have to receive payment from any health insurance plan or other payors for services rendered to Pure Rehab Physical Therapy and the medical professionals caring for me during my treatment. I understand I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payor. I agree to respond to all requests for benefit information and complete any forms required by my insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize Pure Rehab Physical Therapy to submit appeals for payment, including arbitration and formal complaints on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate unless prohibited by law. I understand that Pure Rehab Physical Therapy may request and use data from third parties such as credit reporting agencies in order to verify data and evaluate financial options.

For Medicare/Medicaid. Patients: I certify that the information given by me in applying for payment under Tile XVII and XIX of the social security act is correct. I authorize release of any information needed act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges Pure Rehab Physical Therapy. I understand that I am responsible for any remaining balance not covered by insurance. I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this section including any Medicare deductibles.

Release of Health Information: HIPAA

Pure Rehab Physical Therapy may use and disclose medical information including privileged information to physicians or other healthcare providers for the purposes of providing treatment and to payors for the purposes of payment for medical treatment. HIPAA also permits Pure Rehab Physical Therapy to use medical information for healthcare operations. I expressly authorize Pure Rehab Physical Therapy use and disclosure of my medical information as described in this section.

Consent to contact:

I expressly consent and authorize Pure Rehab Physical Therapy and any practitioner or clinical provider as well as any other related entities, agents, staff or contractors to contact me via phone, email, text message or regular mail. By providing this consent, I specifically waive any claim I may have to the making of such calls including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 USC 227. By providing a telephone number, I represent that I am the subscriber or owner and have the authority to use and provide consent to call the number. I also understand that I may revoke my consent to contact any time by directly contacting Pure Rehab Physical Therapy or by using the opt out or unsubscribe method in emails. I also understand it is my responsibility to contact the office to notify of any changes in phone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or their representative, and that I am authorized to sign this document and accept its terms.

Signature of patient or representative_____

Relationship to patient if applicable_____

Date_____

Cancellation Policy

Please be advised that this policy is in effect to enable us to provide the best care for all our patients. Last minute cancellations or "no shows" take up spots that other patients could use to speed their recovery.

You are required to provide 24 hours notice prior to cancellation of your appointments. If you "no show" or cancel without 24 hours prior notice you will be charged a fee of $30.

I have read and understand the cancellation policy and agree to abide by this policy.

Name_____

Date_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and the patient has had the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

_____

Signature

_____

Printed Name-Patient or Responsible Party

_____

Date

_____

Relationship to patient (if other than patient)

I authorize release of my protected health information to:

_____

Name of authorized person

_____

Name of authorized person

_____

Name of authorized person

Patient Information Form

First Name _____ MI _____ Last Name_____

Sex F M Date of Birth_____ Social Security #_____
(circle one)

Address _____ City_____ State_____
Zip_____

Home Phone_____ Cell Phone#_____

Primary Language_____

Appointment Reminders

Email Address_____ Sign up for Email____ Text____ Call____

Phone # _____

Emergency Contact

Name_____ Relation _____ Phone _____

Name_____ Relation _____ Phone _____

How did you hear about us?_____

Preferred method of instructional materials? Video link via email____ video link via cell phone____

Printed materials_____

Do you have any special learning needs or spiritual considerations that should be addressed for your treatment? If yes, please describe. _____

_____

Do you ever feel physically unsafe in your home? If yes, please describe. _____

_____

Do you ever have thoughts of self-harm? Yes _____ No _____ We will be happy to assist you in finding assistance if requested.

Current Medication List

Patient Name_____

Medication (include strength) List OTC and Rx	Dosage	Frequency	Reason	Last taken

Drug allergies, if known_____

Patient Signature_____ Date_____

Reviewed by_____ Date _____

MEDCIAL HISTORY FORM

Patient Name_____ DOB_____ Next MD Visit_____

Reason for Coming to Therapy _____

When did the problem begin? _____

Have you had this problem before? If yes, please explain. _____

_____

Any treatment for this problem? _____

Have you had physical therapy before? If yes, please explain _____

_____

Are you a smoker? Yes___ No___ Use smokeless tobacco? Yes ___ No ___

Could you be pregnant? Yes ____ No ____ Allergic to latex? Yes ____ No ____

Please check all the following conditions that apply regarding your medical history:

Condition		Condition		Condition		Condition	
Allergies		Anemia		Arthritis		Asthma	
Aneurysm		Alcohol Use		Blood Clots		Hi or Lo Blood pressure	
Cancer		Heart defect		Depression		Diabetes 1 or 2	
Dizziness		Emphysema		Epilepsy		Difficulty Speaking	
Fainting		Fatigue		Fibromyalgia		Frequent Falls	
Glaucoma		Gout		Head Injury		Headaches	
Hearing issues		Hepatitis		Hernia		Heart Disease	
HIV/AIDS		Incontinence		Insomnia		Kidney Stones	
Leukemia		Lupus		Liver disease		Memory problems	
Osteoporosis		Night Sweats				Mental Health issues	
Pacemaker		Scoliosis		Stroke		Metal Implants	
Seizures		Sciatica		Thyroid issue		Multiple Sclerosis	
Tuberculosis		Sickle Cell		Swelling		Shortness of Breath	
Difficulty swallowing		Peripheral Vascular Dis.		Parkinson’s		Vision Problems	

Other, Please list: _____

_____

Previous Surgeries: _____

_____