Saylor Physical Therapy

www.SaylorPT.com

Personal Profile

Date: ____/____/______

Name: First ________________________________ Last ______________________________

Date of Birth ______/_______/______ SS# ______-____-______

Responsible Party SS# ______-____-______ Responsible Party Date of Birth _____/______/______

Address: ____

City: ________________________ State: ________ Zip: _________

Home Phone: ________________ Cell Phone: _______________

Email Address: ____

Work Phone: ________________ Fax: _____________________

Marital Status: Married Single Other

Occupation: ____

Referred By: ____

Age: ________ YRS Height: _______ FT Weight: _______ LBS

Family Physician: __________________________ Phone: _______________________

Emergency Contact:

Name: ____________________________ Relation: _____________________________

Address: ____

Home Phone: ________________ Cell Phone: ________________

Goals:

____

____

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revised 5.30.2019

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Health History

NAME: ____ DATE: _______ / ___ ___ / _______

PLEASE CIRCLE "Y" FOR YES OR "N" FOR NO AND FILL-IN THE BLANKS AS NECESSARY. THANK YOU.

1. (Y / N) DO YOU SMOKE?
2. (Y / N) DO YOU HAVE ANY KNOWN CARDIOVASCULAR PROBLEMS (ABNORMAL ECG, PREVIOUS HEART ATTACK, ATHEROSCLEROSIS, ETC.)?
 IF YES, PLEASE INDICATE.____
3. (Y / N) DO YOU TAKE A STATIN FOR CHOLESTEROL?
4. (Y / N) PLEASE LIST ANY PAST ORTHOPEDIC PROBLEMS?
 ____
5. (Y / N) ARE YOU PREGNANT OR POSTPARTUM LESS THAN SIX WEEKS?
6. (Y / N) ALLERGIES: ____
7. PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING BELOW. ____________________________
 ____
 ____
8. PLEASE REVIEW THE LIST OF CONDITIONS BELOW AND CIRCLE ALL THAT APPLY TO YOU.

CHEST PAIN	CANCER	BLADDER DIFFICULTIES
HEART PALPITATIONS	SEIZURES OR EPILEPSY	INFECTIONS
SHORTNESS OF BREATH/ASTHMA	DIFFICULTY WALKING	ULCERS
DIZZINESS OR BLACKOUTS	JOINT PAIN OR SWELLING	AREAS OF SWELLING
LOSS OF BALANCE	PAIN AT NIGHT	WEIGHT LOSS OR GAIN
COORDINATION PROBLEM	DIFFICULTY SLEEPING	UNEXPLAINED PAIN
WEAKNESS	LOSS OF APPETITE	FEVER
CHILLS OR SWEATS	STROKE	BOWEL DIFFICULTIES
FRACTURES	NAUSEA OR VOMITING	HEADACHES
OSTEOPOROSIS/OSTEOPENIA	DIFFICULTY SWALLOWING	HEARING PROBLEMS
VISION PROBLEM	HIGH BLOOD PRESSURE	DIABETES
HIGH CHOLESTEROL	HIV/AIDS	

Other:

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Release of Information

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the form accordingly. We thank you for your help and understanding.
I, ___________________________________, authorize Saylor PT and its staff to release information regarding my condition to the following people:
1.____ 4.____
2.____ 5.____
3.____ 6.____

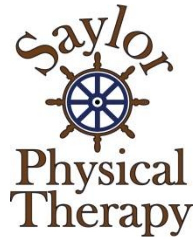
Patient Signature ______________________________________ Date ____/_____/________

Note: Please include everyone's name that you are allowing for us to release information to including, but not limited to: spouse, child, physicians (other than referring), relatives or friends. If the name is not listed above, we are unable to speak to or release information to them.

Payment Policy

It is our policy that patients are directly responsible for their charges if we are not a contracted provider with the patient's insurance company and payment for services rendered for these coverages will be anticipated at the time of care. If your coverage is with a health care provider we are contracted with, the patient will be responsible for the patient financial responsibility the insurance company advises and will be billed for same after billing has been submitted to and processed by the insurance company. Charges applying to co-insurances, deductibles or co-pays reported will be considered the patients responsibility.

Patient Signature ____________________________________ Date _____/_____/_________



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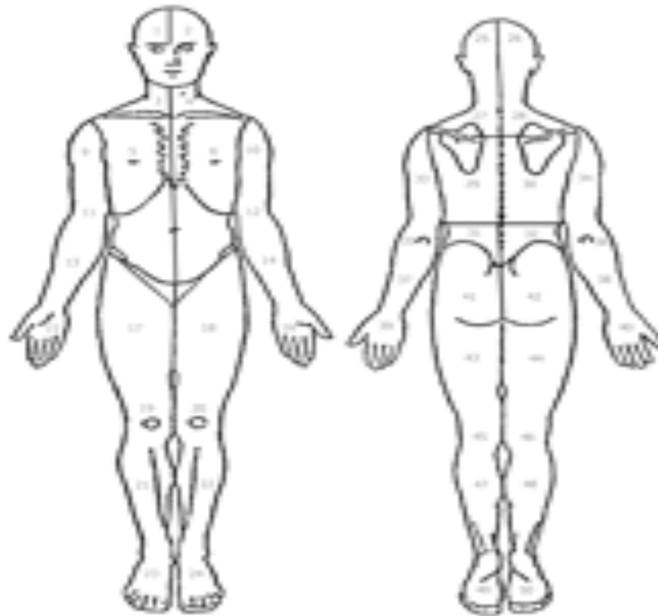
Name:________________________________ Date:_______________________

Please use the drawings below to indicate where you are experiencing symptoms NOW.

Use the following key to indicate different types of symptoms:

Ache = **ZZZ** Stabbing = **XXX** Burning = //////// Pins/Needles = **000** Stiffness = ^^^^



Please indicate the intensity of your symptoms below.

RATE THE INTENSITY OF YOUR SYMPTOMS

0 = N0 Pain Excruciating Pain = 10

PAIN AT ITS WORST

0 1 2 3 4 5 6 7 8 9 10

PAIN AT ITS LEAST

0 1 2 3 4 5 6 7 8 9 10

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<u>Informed Consent</u>

I, ____________________________, hereby consent to voluntarily engage in a physical therapy and wellness training program recommended for the improvement of my general health, well-being and quality of life. I understand the intent of the program will be to provide rehabilitation, post-rehabilitation, fitness training, preventive conditioning and/or sport performance enhancement.

In order to determine my physical capacity to participate in an individualized goal-specific physical therapy and wellness program, I acknowledge that a comprehensive examination is required. The exam will require full disclosure of my present medical condition, past medical history, and physical assessment. Physical assessment procedures will include an examination of my posture, range of motion, joint mobility, muscle flexibility, muscle strength, neurovascular status, and balance/coordination. I understand that I may be required to receive a physician's clearance to participate in an individualized physical therapy and wellness program ***if*** the evaluating therapist deems it necessary after the initial examination. I consent to these procedures and agree, if necessary, to acquire a physician's approval to participate in the physical therapy and wellness training program.

I understand that this program may benefit my physical fitness or general health. However, the program cannot guarantee any particular level of improvement. I recognize that involvement in physical therapy and wellness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort.

I understand and have been informed that there exists the risk of bodily injury during physical therapy sessions including, but not limited to, injuries to muscles/tendons, ligaments, joints and periarticular structures, and adverse responses such as abnormal blood pressure changes, light headedness, fainting, dizziness, abnormal heart rate changes and, in rare instances, heart attack, stroke, or death. Additionally, I understand that I must provide all medical related information to the owners, operators, agents, employees, therapists, and instructors of Saylor PT of any problems, adverse symptoms, and/or desire to discontinue participation.

I have been informed that the information obtained in this program will be treated as privileged and confidential and will not be released to any person without my express written consent except as required by law. I agree to the use of any information for the purpose of consultation with other health /wellness professionals, including my doctor. Any other information obtained, however, will only be used by the owners, operators, agents, employees, therapists, and instructors of Saylor PT in the course of recommending interventions for me and evaluating my progress in the program.
I have been given the opportunity to ask questions as to the procedures of this program and, by my signature, I fully consent to participate in consideration of the aforementioned advisements.

PARTICIPANT____DATE_______________

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<u>Notice of Privacy Practices Acknowledgement</u>

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments, research, and physical therapist reviews.

I have received, read and understand the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Saylor Physical Therapy at any time to address any concerns regarding the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my required restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________________

Patient Signature: ___________________________________

Date: ___________________

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Cancellation Policy

Our physical therapists fully commit one hour of their time to your recovery and attending all scheduled visits is essential to this process.

Effective January 1, 2019 our cancellation fee will be enforced. In order to provide private, one-hour sessions, we ask for you to give us at least a **24 hour** notification to cancel. If less than 24 hours notification is given, you will be responsible for the **cancellation fee of $75.** Thank you for your understanding in this important matter, Saylor Physical Therapy believes that private, one-hour sessions is the quality of care that you deserve.

Additionally, please make sure you are on time for your appointments, and if 3 consecutive appointments are cancelled with short notice, it is up to the therapist's discretion to cancel all upcoming visits until your schedule can accommodate consistent attendance.

Payment will be collected prior to ongoing therapy.

Thank you for your understanding of our policy.

____

Patient Name

____

Patient Signature

____

Date