Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed therapist employed by Function First Physical Therapy, LLC. The therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Function First Physical Therapy, LLC for services rendered. Function First Physical Therapy, LLC will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for therapy services.

Patient Information Consent Form (HIPAA)

I have read and fully understand Function First Physical Therapy, LLC's Notice of Information Practices. I understand that Function First Physical Therapy, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Function First Physical Therapy, LLC will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Function First Physical Therapy, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Function First Physical Therapy, LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

I have read and understand the above consents, assignment of benefits, and release of information above.

Patient Signature ____ Date__________________

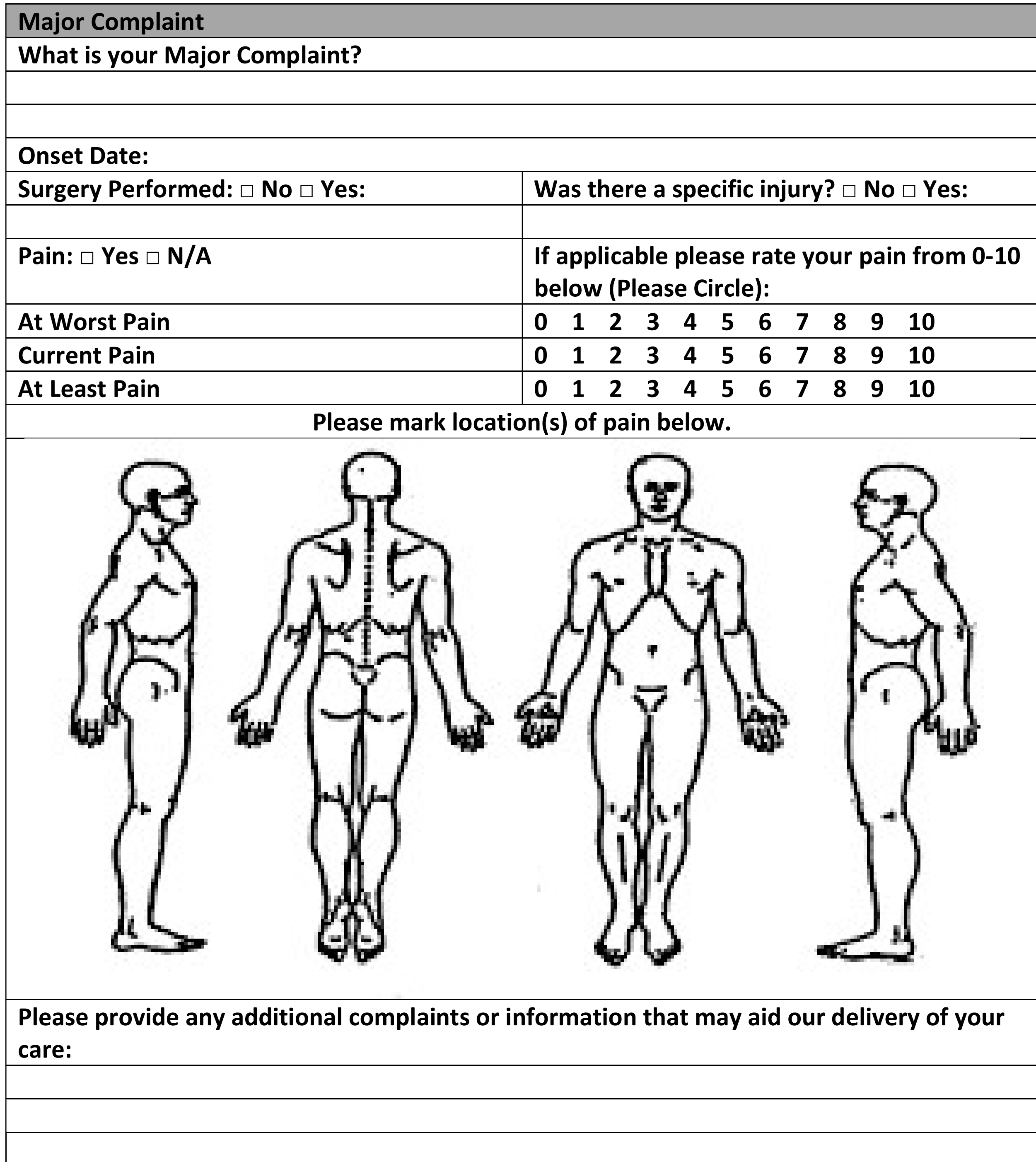
FUNCTION FIRST
PHYSICAL THERAPY

Patient Intake Form		
Personal Information		
Name:	Date:	
Sex:	DOB:	
Address:		
City:	State:	Zip:
Cell phone:	E-mail:	
Would you like to receive appointment reminders? □ No □ Yes If yes, please specify cell phone carrier:		
Emergency Contact:	Phone Number:	
Who referred you?		
Insurance:		
Guarantor of insurance (if not same as patient):	Guarantor DOB:	
Patient History and Current Medical Conditions and Services		
Are you on other therapy services and/or Home Health? □ No □ Yes (If yes, please specify)	Do you currently have an open liability or worker's compensation claim for any medical condition? □ No □ Yes	
Do you have any medical/physical restrictions for activity? □ No □ Yes (If yes, please specify)	Do you have a pacemaker or other implanted device? □ No □ Yes (If yes, please specify)	
Are you pregnant? □ No □ Yes	Allergies? □ No □ Yes (if yes, please specify)	
If yes, how many months?		
Current Medications:		
Past Injuries/surgeries (please specify sx):		
Medical Conditions (Please check all that apply):		
□ No past/current conditions	□ Depression	□ Immunosuppression
□ Alzheimer's Disease	□ Diabetes Mellitus I	□ Lupus
□ Anxiety	□ Diabetes Mellitus II	□ Muscular Dystrophy
□ Cardiovascular Disease	□ Fibromyalgia	□ Obesity
□ Cauda Equina Syndrome	□ High Cholesterol	□ Osteoarthritis
□ Cerebral Vascular Accident	□ High or Low Blood Pressure	□ Parkinson's Disease
□ Current Infection	□ History of Cancer	□ Rheumatoid Arthritis
□ Current Fracture	□ Huntington's Disease	□ Traumatic Brain Injury
□ Other:		

FUNCTION FIRST
PHYSICAL THERAPY

Major Complaint	
What is your Major Complaint?	
Onset Date:	
Surgery Performed: □ No □ Yes:	Was there a specific injury? □ No □ Yes:
Pain: □ Yes □ N/A	If applicable please rate your pain from 0-10 below (Please Circle):
At Worst Pain	0 1 2 3 4 5 6 7 8 9 10
Current Pain	0 1 2 3 4 5 6 7 8 9 10
At Least Pain	0 1 2 3 4 5 6 7 8 9 10

Please mark location(s) of pain below.



Please provide any additional complaints or information that may aid our delivery of your care:

By signing below, I attest that I have provided all relevant information about my current condition that would impact the construction, execution, and billing of a Physical Therapy plan of care.

Signature **Date**