Patient Intake and Consent Forms

TODAY'S DATE_____

NAME_____DOB_____

ADDRESS_____CITY_____

STATE_____ZIP_____ HOME PHONE_____

CELL PHONE_____EMAIL_____

PRIMARY CARE PHYSICIAN_____

REFERRING PHYSICIAN_____

DATE OF INJURY_____

CAUSE OF INJURY_____

Please explain the reason for your visit

_____

_____

_____

How long have you been experiencing symptoms?

_____

DESCRIBE YOUR GENERAL HEALTH (CIRCLE ONE)

EXCELLENT GOOD FAIR POOR

HAVE YOU HAD A RECENT SURGERY OR HOSPITALIZATION? IF YES: WHEN AND WHY?

_____

HAVE YOU HAD PHYSICAL OR OCCUPATIONAL THERAPY THIS YEAR? Y / N

HAVE YOU HAD ANY RECENT IMAGING FOR THIS CONDITION? (X-RAY, MRI, CT SCAN) (CIRCLE ONE) Y / N IF YES, WHAT WERE THE RESULTS IF KNOWN?_____

Please indicate if you are experiencing any of the following conditions or symptoms:

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ CHF
- ☐ Heart Attack
- ☐ Phlebitis/vericose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Nausea
- ☐ Loss of sensation
- ☐ Diabetes
- ☐ Cancer
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Vision problems
- ☐ Ringing in ears
- ☐ Hearing loss

PLEASE LIST CURRENT MEDICATIONS OR PROVIDE A LIST FOR OUR REFERENCE_____

_____

_____

_____

_____

PLEASE DESCRIBE ANY OTHER MEDICAL CONCERNS YOU MAY HAVE_____

General Consent

I, _____, hereby consent to receive physical therapy treatment from AMR Physical Therapy.

I understand that physical therapy is a treatment for various conditions, including but not limited to, pain, weakness, and limited mobility. Physical therapy may involve manual therapy, exercises, modalities, and other treatments deemed necessary by my physical therapist.

I acknowledge that physical therapy may cause temporary discomfort or soreness and I assume the risks associated with physical therapy treatment. I understand that I am responsible for communicating any discomfort or pain to my physical therapist.

I hereby authorize AMR Physical Therapy to release any information regarding my physical therapy treatment to my physician(s) and/or other healthcare providers as deemed necessary.

I acknowledge that I have the right to refuse treatment and to discontinue physical therapy at any time.

I acknowledge that I have been informed of my rights as a patient receiving physical therapy and have had the opportunity to ask questions and receive answers to my satisfaction.

Signature_____ Date_____

Privacy and Sharing of Information

I authorize AMR Physical Therapy and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize AMR Physical Therapy and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature_____ Date_____

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file.

Signature_____ Date_____

Assignment of Benefits

I hereby assign to AMR Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with AMR Physical Therapy and to provide such information as is needed to establish my eligibility for such benefits.

Signature_____ Date_____

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

Signature_____ Date_____