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 physical therapist employed by Activate Physical Therapy and Wellness. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical 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 Activate Physical Therapy and Wellness for services rendered. Activate Physical Therapy and Wellness 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 physical therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand Activate Physical Therapy and Wellness' Notice of Information Practices. I understand that Activate Physical Therapy and Wellness 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 information is used and disclosed for treatment, payment, and administrative operations. I also understand that Activate Physical Therapy and Wellness will consider requests for restrictions on a case-by-case basis but is not required to oblige such requests.

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 be used in place of the original.

Designated Individuals Authorization

I, ____________________, hereby authorize one or all of the designated parties below to request and receive any of the protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals' authorization.

Patient (or guardian) signature: ________________________________ Date: ________________

PATIENT COMMUNICATION PREFERENCES

Please provide the best email for reliable communication with you:

Email: ____________________________________

Do you prefer text or email reminders?

Please circle one: Text Email no reminders, please

Cell phone: ___________________________

Home phone: _________________________

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, your personal exercise program, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided contact information.

____ I agree that Activate Physical Therapy and Wellness can use my cell phone number
(initial) I provided to communicate using the Google Voice text line (701)404-9060

Patient (or guardian) signature: ____

Date: _______________________

INSURANCE AND PAYMENT OPTIONS

PLEASE INITIAL NEXT TO THE PAYMENT OPTION YOU ARE USING

______ *initials*

PRIVATE PAY -- Not using insurance, I am paying by cash, check or credit card at the time of service.

You have been offered the opportunity to personally pay for your physical therapy evaluation and treatment at Activate Therapy and Wellness. The private pay policy is used in the following circumstances:

1. Patient has no insurance
2. Physical Therapy is not covered by patient's insurance
3. Patient chooses to forego insurance benefits

The following conditions apply:

1. Once you have chosen the private pay terms, we will not bill your insurance carrier for services rendered.
2. **Payment is due at the time of service.**

______ *initials*

HEALTH INSURANCE

Primary Insurance Company: ______________________________ Phone #: ______________

Plan ID#: ______________________________ Group #: ______________________________

Policy Holder: ______________________________ Date of Birth: _____/______/______

Secondary Insurance Company: ______________________________

Patient is responisble for any copay, coinsurance or deductible dictated by their insurance plan.

______ *initials*

WORKERS COMPENSATION

Primary Insurance Company: ______________________________ Phone #: ______________

Claim #: ______________________________ Name of Adjuster: ______________________

Employer Insuring the Claim & Phone: ______________________________ (____) ______ - ________

Date of Injury: ______________________________

______ *initials*

AUTO INSURANCE/MED PAY

Auto Insurance/Med Pay Company: ______________________________ Phone #: ______________

OR Auto ins/Lien Company: ______________________________ Phone #: ______________

Claim #: ______________________________ Name of Adjuster: ______________________

Adjuster Phone #: ______________________________ Date of Injury: ______________________

In the event that the medical on the auto policy above is exhausted, please bill the following (select one):

- ☐ Private health insurance. Patient is responisble for any copay, coinsurance or deductible dictated by their insurance plan.
- ☐ Private pay; patient agrees to pay by cash, check or credit card

We accept cash, VISA, MC or check. There is a $25.00 service charge for returned checks.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.

Printed name of patient **Signature of Patient or Responsible Party** **Date**

Patient Name: ______________________ Patient Date of Birth: ______________

Patient Address: ____

Emergency Contact: ______________________ Relationship: ______________

Emergency Contact Phone #: ______________________

Exisiting or Previous Medical Conditions

Condition			Condition			Condition		
Allergies	□ Yes	□ No	Diabetes	□ Yes	□ No	Metal Implants	□ Yes	□ No
Anemia	□ Yes	□ No	Dizzy Spells	□ Yes	□ No	MRSA	□ Yes	□ No
Anxiety	□ Yes	□ No	Emphysema/Bronchitis	□ Yes	□ No	Multiple Sclerosis	□ Yes	□ No
Arthritis	□ Yes	□ No	Fibromyalgia	□ Yes	□ No	Muscular Disease	□ Yes	□ No
Asthma	□ Yes	□ No	Fractures	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Autoimmune Disorder	□ Yes	□ No	Gallbladder Problems	□ Yes	□ No	Parkinsons	□ Yes	□ No
Cancer	□ Yes	□ No	Headaches	□ Yes	□ No	Rheumatoid Arthritis	□ Yes	□ No
Cardiac Conditions	□ Yes	□ No	Hearing Impairment	□ Yes	□ No	Seizures	□ Yes	□ No
Cardiac Pacemaker	□ Yes	□ No	Hepatitis	□ Yes	□ No	Smoking	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Speech Problems	□ Yes	□ No
Circulation Problems	□ Yes	□ No	High/Low Blood Pressure	□ Yes	□ No	Strokes	□ Yes	□ No
Covid-19	□ Yes	□ No	HIV/AIDS	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Currently Pregnant	□ Yes	□ No	Incontinence	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Depression	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Vision Problems	□ Yes	□ No

Latex allergy □ Yes □ No Adhesive allergy □ Yes □ No

In the past 3 months have you experienced any of the following?

Change in your health	□ Yes	□ No	Nausea/Vomiting	□ Yes	□ No
Shortness of Breath	□ Yes	□ No	Unexplained Weight Change	□ Yes	□ No
Fever/Chills/Sweats	□ Yes	□ No	Change in appetite	□ Yes	□ No
Numbness/Tingling	□ Yes	□ No	Change in bowel/bladder	□ Yes	□ No

If you answered "Yes", please describe____

____

____

Injury as a result of a fall in the past year? □ Yes □ No

Two or more falls in the last year? □ Yes □ No

I currently have difficulty with the following daily activities as a result of my condition:

____

____

____

____

____

PLEASE LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. PLEASE CIRCLE THE METHOD, LIST THE DOSAGE AND CIRCLE THE FREQUENCY BY WHICH YOU TAKE THEM.

Medications, Vitamins, Supplements	Method (Circle One)	Dosage	Frequency (Circle One)
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:

BODY MASS INDEX (BMI) – TO BE COMPLETED BY THERAPIST OR OTHER EXCEL SUPPORT STAFF (*Medicare Patients Only*):

Weight: ____________ Height: ____________ Calculated BMI (*For Internal Use Only*): ____________

Normal Parameters: *Age 65 years and older - BMI ≥ 23 and < 30* *Age 18-64 years - BMI ≥ 18.5 and < 25*

I hereby conset to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under Activate Physical Therapy and Wellness. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.

I am aware that there is not a guarantee that the proposed course of treament will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.

In regard to communication with my therapist, I am aware that e-mail and text messaging is not a secure method of communicating. By initiating or responding to an e-mail or text message, I am giving my consent to communicate in this manner and understand that there are risks to my protected health information. By providing your above contact information and signing below, you agree to receive information via the communication channels for which you provided contact information.

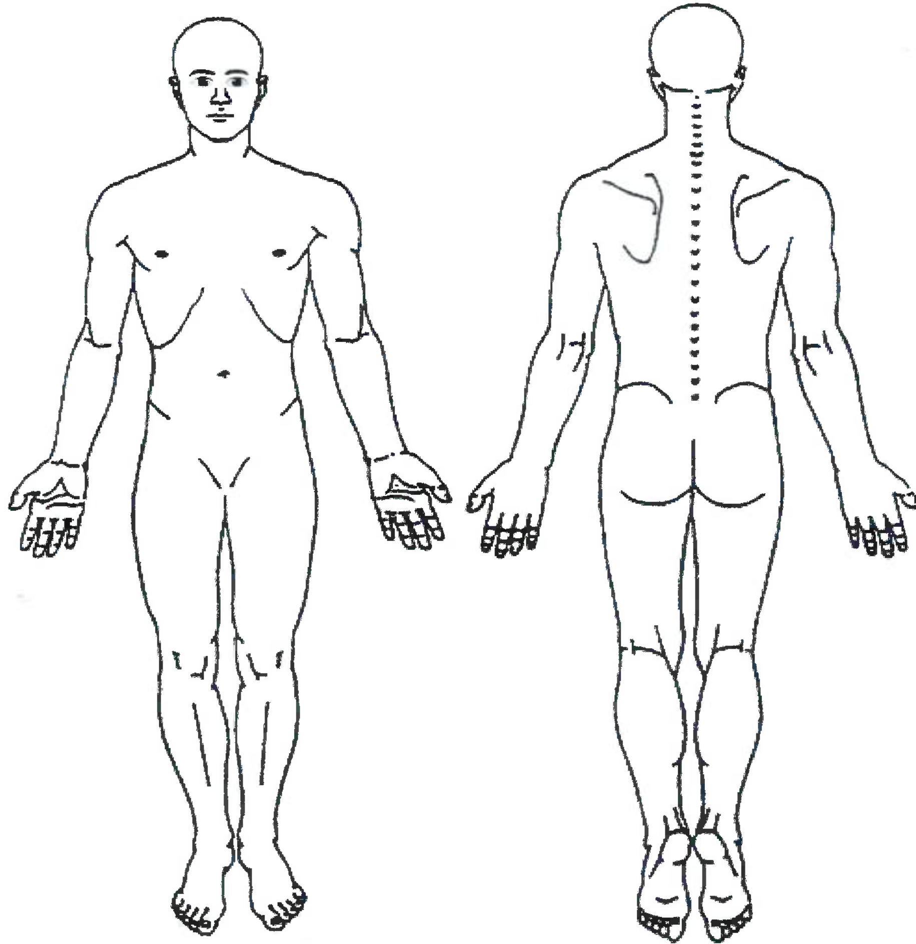
NO SHOW POLICY: Failure to call or show for an appointment will result in $50 No Show fee. Please call our office if you cannot come to an appointment already scheduled.

Patient (or guardian) signature ______________________________ **Date** ______________

Form has been read and reviewed by Therapist?? **Yes** **No** **PT Initals**____________

Use the following drawing and symbols to indicate the location and type of symptoms you are experiencing at the present time

SHARP PAIN	ACHINESS	BURNING	PINS & NEEDLES	NUMBNESS
/////	XXXXX	!!!!!	00000	+++++



Current Pain ________

Best pain since onset ________

Worst pain since onset ________

Average pain ________