INNER DYNAMICS PHYSICAL THERAPY

Last Name:_____ Date of Birth:_____Age:_____
First Name:_____ Social Security #:_____
Address:_____ Gender: M or F Marital Status: M S D W
_____ Referring Doctor:_____
Cell Phone:_____ Diagnosis:_____
Home Phone:_____ Date Problem Started:_____
Work Phone:_____ Date of Surgery:_____
E-Mail:_____

INSURANCE INFORMATION

Primary Insurance:_____
Policy ID#:_____Group #_____
Phone #:_____
Effective Date:_____ Subscriber:_____
Relationship to Subscriber:_____ Subscribers Date of Birth:_____

Secondary Insurance:_____
Policy ID#:_____Group #_____
Phone #:_____
Effective Date:_____ Subscriber:_____
Relationship to Subscriber:_____ Subscribers Date of Birth:_____

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/ Legal Guardian Name:_____ **Emergency Contact:**_____
Address(if different that child):_____ Relationship:_____
_____ Contact Cell Phone:_____
Phone#:_____ Contact Home Phone:_____

I, the above named person (or their legal guardian), consent to the administration of treatment rendered via Inner Dynamics Physical Therapy(IDPT) and its professional staff as prescribed by my physician. I authorize the release of any records of information about me to obtain payment for charges incurred by me at IDPT, and for the purpose of communicating with my physician or other health care provider. I agree to pay IDPT any charges that I am responsible for such as co-pays, co-insurance, or any non-covered charges. I hereby assign benefits, otherwise payable to me or my dependents, directly to IDPT. I understand that IDPT, will verify my insurance, but I realize benefits will not be guaranteed by this office, and I am ultimately financially responsible for my account. I agree that I have been advised of my benefits as they were explained to IDPT by my insurance company.

Signature of Patient or Guardian:_____Date:_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & 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:

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

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of 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 health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

If you wish for us to talk about your care to anyone else please list their name and relationship to you (ex: spouse, mother, father, brother, sister, power of attorney).

_____

_____

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

INNER DYNAMICS PHYSICAL THERAPY

EMAIL COMMUNICATION AND NEWSLETTER FORM

NAME:_____

EMAIL ADDRESS:_____

If you would like to receive email reminders for upcoming appointments at **Inner Dynamics Physical Therapy**, please check here.

___ **Yes,** I would like to receive **emails** for my upcoming appointments.

___**No,** I would like to receive **phone calls** for my upcoming appointments.

As a new patient, we invite you to learn more about what's going on at **Inner Dynamics Physical Therapy** via our weekly newsletter!

We love sending out information including:

- New videos posted to facebook, youtube or instagram of exercise routines
- Future activities or events
- Research articles
- Motivational quotes or stories
- Updates regarding our practice

Please check here.

___**Yes,** please sign me up for your weekly newsletter.
___**No,** I do not want to receive updates and inspirational stories.

At any time you can opt-out of our email services. No personal information will be shared via our email services unless a patient has provided full disclosure to share a story with others. Your email address will only be used for the sole purposes listed above and will never be utilized for any other services.

Orthopedic and Spine History Form
Inner Dynamics Physical Therapy

Name _____ D.O.B _____ Age_____ Date _____

Date of last M.D. visit: _____/ _____ /_____ Referring Physician: _____
Primary Care Physician _____
Occupation/Job Description _____
General Health : Good - Fair - Average - Poor
Current level of stress: High _____ Moderate _____ Low _____
Date of Last Physical Exam: _____
Tests performed _____
Leisure Activities/ Exercise _____

How did you choose our facility? (Please circle)
Physician, Family, Friend, Location, Advertisement, Other _____

1. Describe the current problem that brought you here:

_____
_____

2. When did your problem first begin? (Approx. date)

_____

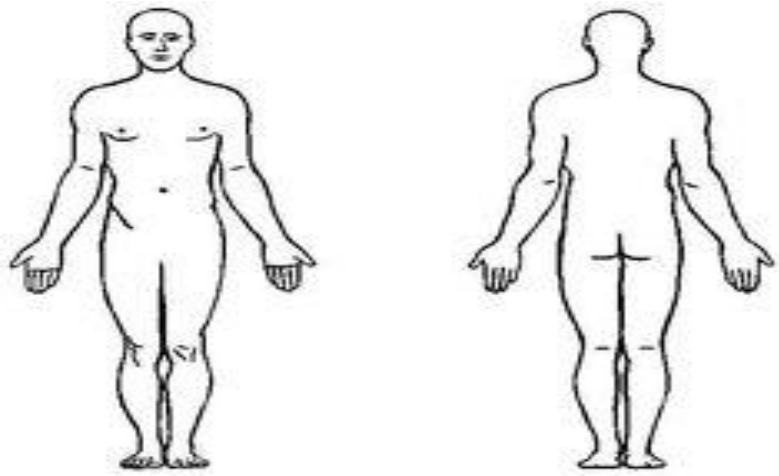
3. How did your problem begin? Was there one specific incident that instigated your problem? If yes, please describe:

_____
_____

4. Since your problem began, is it: ___ improving, ___staying the same, ___ getting worse?
a. Why or how?

_____

5. Please note on the diagram, where you are experiencing pain. Mark area(s) with X.



6. Describe previous treatment to address problem.

_____

_____

7. Is your pain constant or does it come and go? (Please Circle)
a. Constant b. Intermittent

8. Describe the nature of your pain using the following choices (please circle) or write in your own description.
Tingling, Sharp, Shooting, Burning, Radiating, Localized, Achy, Cramping, Tender, Sore
Other, please explain: _____

9. Rate your pain on a scale of 0- 10 with 0 being no pain and 10 meaning the pain is so bad you need to go to the emergency room.
a. ___/ 10 at the worst b. ___/10 at the best c. ____/10 currently

10. Activities/events that cause or aggravate your symptoms. Please check all that apply.

___ sitting greater than ___ minutes ___ with lifting/bending
___ standing greater than ___ minutes ___ vigorous activity
___ walking greater than ___ minutes ___ coughing/sneezing/straining
___ changing positions (sit to stand) ___ bowel or bladder movements
___ light activity (household chores) ___ no activity affects the problems

___ Other, please explain: _____

11. Are there any activities or positions that significantly improve your symptoms/relieve your symptoms?

_____

12. Are you currently receiving treatment with any other provider? If yes, please list the provider and for what reason.

_____

_____

13. Have you had prior treatment for this condition?

_____

14. Recent diagnostic tests? (please circle and list findings)
a. X-ray b. CT scan c. MRI d. EMG f. Bone Scan g. Other

_____

_____

15. Since the onset of your current symptoms have you had:

Y/N Fever/ chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Changing in bowel or bladder functions
Other:_____
Y/N Malaise (unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Unexplained muscle weakness
Y/N Numbness/ tingling

16. Have you ever had any of the following? (please check all that apply)

Cancer	Epilepsy/seizures	Emphysema/chronic bronchitis
Heart conditions	Multiple Sclerosis	Asthma
High blood pressure	Head injury	Latex Sensitivity
Dizziness	Osteoporosis	Hypothyroid/Hyperthyroid
Ankle swelling	Chronic Fatigue Syndrome	Heachaches
Low back pain	Fibromyalgia	Diabetes
Alcoholism/ Drug Abuse	Arthritic Conditions	Kidney disease
Depression	Stress Fracture	Irritable Bowel Syndrome
Anorexia/bulimia	Acid Reflux	Hepatitis
Smoking history	Joint replacement	Sexually transmitted disease
Vision/eye problems	Bone fracture	Physical or sexual abuse
Hearing loss/problems	Sports injury	Pelvic pain
Stroke	TMJ /neck pain	Metal implants
Fatigue	Pacemaker	Ulcers

Other:_____
Allergies: _____

17. Past surgical history (please list any surgeries you have had with approximate dates:

_____
_____

18. Please list all medication/supplements you are currently taking:

Medications (pills, injections, patch)	Start Date	Reason for taking

Over the counter (vitamins)	Start Date	Reason for taking

19. Goals for physical therapy

_____
_____

Patient Signature: _____

Physical Therapist Signature: _____

Consent for Evaluation and Treatment

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks:

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits:

I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives:

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy:

I understand that if I cancel more than 24 business hours in advance, I will not be charged. I understand that if I cancel less than 24 business hours in advance, weekends are not business hours, I will pay a cancellation fee of $45.
Initials_____

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists at Inner Dynamics Physical Therapy.

Date:_____ Patient Name:_____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

_____
Witness Signature

Plan of Care Agreement

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program have all been explained to me. My questions about my care have been answered to my understanding and satisfaction. I consent to the recommended course of treatment.

For optimum care and progress:

- It is important to keep your regularly scheduled therapy appointment. At those visits, we can modify and progress your exercise routine.
- Please avoid practicing your pelvic floor exercises just before your next appointment time.
- Bring your exercise sheets, voiding log, and biofeedback internal sensors and any other equipment that may be needed to each office visit.

Date

Patient Name (Please Print)

Patient Signature

Signature of Parent or Guardian
(If applicable)

Therapist Signature