SPOONER

WELCOME TO SPOONER PHYSICAL THERAPY

Thank you for choosing **Spooner Physical Therapy** as your healthcare partner. Please carefully read each section below, sign and date at the bottom. Our team is here to assist you if you have any questions.

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed.

There are certain inherent risks with Physical/Occupational Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort, or could aggravate your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

The Physical/Occupational Therapist and/or Physical/Occupational Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical/ Occupational Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS: For personal safety, do not use any equipment without a team member present.

NOTICE OF PRIVACY PRACTICES

I have read and fully understand Spooner Physical Therapy's Notice of Privacy Practices. I understand that if I wish to receive a printed copy of the Notice of Privacy Practices, I can request it at any time.

I authorize the use and disclosure of my personal health information for purposes as noted in Spooner Physical Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT INFORMATION CONSENT

I authorize Spooner Physical Therapy to use my protected health information for targeted marketing purposes, and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing.

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PATIENT FINANCIAL RESPONSIBILITY

Spooner Physical Therapy will contact your insurance provider and verify your benefits as accurately as possible. Please keep our team informed of any changes to your personal information and/or health insurance information so that your claims will process promptly and fully. It can take 4-8 weeks for the insurance company to process your claims. I authorize Spooner Physical Therapy to bill my health insurance on my behalf and I thereby assign all medical benefits to Spooner Physical Therapy.

I understand and acknowledge that I am financially responsible for payment of services provided to me and that I will pay at the time of service, whether I am using insurance or not. This includes, but is not limited to co-payments, coinsurance, and deductibles that are not covered by my health insurance. I understand that verification of my insurance benefits is not a guarantee of payments, and that the insurance company determines benefit payments.

I understand that a $25 cancellation/no show fee will be added to my balance if I do not notify the clinic that I am unable to keep my appointment 24 hours prior to the scheduled time.

I understand that I will receive a statement for all unpaid services if I do not pay at the time of service. If I fail to pay my account balance in full after three final statements, I understand that my account may be referred to a collection agency.

I have read and understand the above information.

Patient Name _____

Patient Signature _____ **Date** _____

Legal Guardian Signature _____ **Date** _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name _____ Relationship _____

Name _____ Relationship _____

SPOONER

PATIENT HEALTH HISTORY

Patient Name _____ Clinic _____ Date _____

List medications you are currently taking _____

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Asthma	☐	☐		Fracture/Broken Bones	☐	☐	
Diabetes	☐	☐		Neuromuscular	☐	☐	
High Blood Pressure	☐	☐		Dizziness/Blackouts	☐	☐	
Heart Problems	☐	☐		Headache/Migraine	☐	☐	
Lung Problems	☐	☐		Blood Clots/Vascular	☐	☐	
Cancer	☐	☐		Bladder/Bowel Disorder	☐	☐	
Seizures	☐	☐		Pregnancies # _____			Dates _____
Arthritis	☐	☐		Other _____			
Stroke/CVA	☐	☐					

SURGICAL	YES	NO	DATE	Please Describe
Joint Replacements	☐	☐		
Orthopedic Surgery	☐	☐		
Heart Surgery	☐	☐		
Fracture Reductions	☐	☐		
Joint Manipulations	☐	☐		
Spinal Surgery	☐	☐		

Other Surgeries _____

Please list your current limitations/restrictions _____

DIAGNOSTICS	YES	NO	DATE	Results
X-Rays	☐	☐		
CT Scan	☐	☐		
MRI	☐	☐		
EMG Nerve Studies	☐	☐		
Injections	☐	☐		

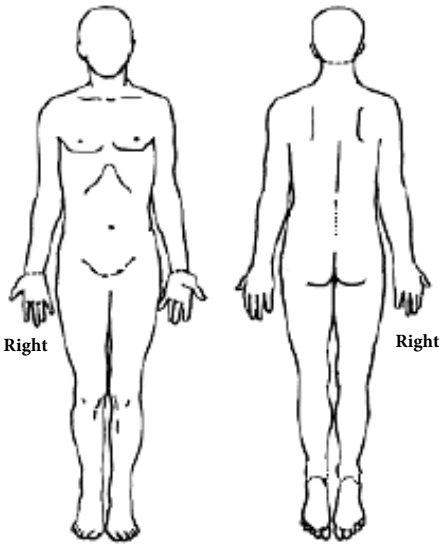
PAIN/SYMPTOMS

- Please mark your pain on an average day by marking a number on the scale below.

0 _____ **10**
No Pain **ER Visit**

- On the Body Diagram to the right, describe your symptoms using the following symbols:

(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning



Have you received home health physical, occupational or speech therapy recently?	☐ **Yes**	☐ **No**
Is your injury a result of an auto accident or a work-related injury?	☐ **Yes**	☐ **No**
Have you had two or more falls in the past year?	☐ **Yes**	☐ **No**
Have you had a fall in the past year that resulted in injury?	☐ **Yes**	☐ **No**

Patient Signature _____ Date _____

Legal Guardian _____ Date _____