CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Breakaway Physical Therapy, LLC to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ Responsible Party Initials/date

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL -RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Breakaway Physical Therapy, LLC to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Breakaway Physical Therapy, LLC from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Breakaway Physical Therapy, LLC and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Breakaway Physical Therapy, LLC, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials/date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I have received a copy of Breakaway Physical Therapy, LLC Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Breakaway Physical Therapy, LLC to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Breakaway Physical Therapy, LLC will always post the current notice at the clinic, on the website and have copies available for distribution. I understand I may refuse to sign this form

_____ Responsible Party Initials/date

We may need to contact you. Do we have your permission to leave a message at the phone numbers you provide us?

Home Telephone_____

☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to leave message with family members or other persons living in the same household

Work Telephone_____

☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to leave message with secretary, assistant, or another individual who regularly answers the phone

Cell Telephone_____

☐ OK to leave message with detailed information
☐ Leave message with call-back number only

Email (Please specify email address) _____

I would like to receive relative information from Breakaway Physical Therapy, LLC.
☐ I would not like to be contacted via email

How would you like to receive your appointment reminders (circle one): **TEXT** **VOICE CALL** **EMAIL**

Indicated below are individuals whom Breakaway Physical Therapy, LLC may speak to regarding my treatment.

Please list name and telephone number:

Spouse: _____ Father: _____

Mother: _____ Other: _____

Indicate name and telephone number of the person you would like us to list as your emergency contact:

Name: _____ Phone: _____

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient / Guardian/Responsible Party Signature:

_____Date _____

Cancellation Policy

Scheduling and keeping your therapy appointments is crucial to the recovery process. Your appointments will be scheduled according to your therapy needs. If you are unable to keep an appointment, 24 hours advanced notice by phone is required. We will do our best to reschedule for the same week, however we cannot guarantee another appointment will be available.

If the appointment is unable to be rescheduled, cancellations made less than 24 hours before an appointment, as well as no call, no shows, will result in a **$75 fee not covered by insurance.**

As keeping your therapy appointments is crucial to your recovery, if you continue to miss your appointments it will be at the therapist's discretion as to whether to discharge your plan of care.

Initials _____

Late Policy

We respect our patient's time by running as close to schedule as possible. If you are going to be late, please give us as much notice as possible by phone. Please be aware that being late may result in the therapist having to adjust your treatment time. In the event of that you will be significantly late, we will do our best to accommodate your treatment as our fluctuating schedule allows. However, we cannot make any promises that you will be seen for your appointment at its scheduled time slot if you are significantly late. If you decide to forgo your appointment, the $75 cancellation fee will apply.

Initials _____

Child Policy

We are a family friendly office that welcomes you and your children. We care very much about your treatment and want to be able to facilitate your therapy needs as much as possible. We have a wide selection of toys and activities for all ages in the waiting area. Children are welcome in the gym as well when supervised by a parent. However, the therapist and aides are here to facilitate your treatment and cannot be responsible for supervising your children. If the office is busy, we may ask that you continue your treatment in one of the private treatment rooms to ensure a positive experience and safety for everyone.

Initials _____

Patient Signature _____ Date_____

Breakaway Physical Therapy

Intake Form

Name: _____ Date: _____ DOB: _____ Age: _____

Sex: M/F Hand Dominance: R/L Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Driver's License #:_____ State/Exp: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Occupation: _____ Current Work Status: _____ Lifting Restrictions: Y/N

Family Doctor: _____ Referring Doctor: _____

Insurance Information

Primary Insurance Company: _____

Subscriber ID #: _____ Group #: _____

Plan Name/Type: _____

Policy Holder Name: _____ Holder DOB/Relationship: _____

Insurance Address: _____ Phone Number: _____

Secondary Insurance: _____

Subscriber ID #: _____ Group #: _____

Plan Name/Type: _____

Policy Holder Name: _____ Holder DOB/Relationship: _____

Insurance Address: _____ Phone Number: _____

Previous physical therapy? _____

How did you hear about us? _____

Health History

Name:_____ Date:_____ DOB:_____

Presenting Injury:_____ Date of injury:_____

If an accident, circle where it occurred: **Home Auto Work Sports Other N/A**

Next Doctor's Visit (referring physician):_____ N/A

Goals of physical therapy:_____

Do you live alone? Y / N Are stairs at your home? Y / N

Do you currently use a: Cane Walker Crutches Wheelchair No

Have you had any diagnostic tests for this problem? (circle all that apply)

X-rays Bone scan Doppler ultrasound MRI EMG CT scan Bloodwork Other None

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Have you RECENTLY noted any of the following? (Check or circle what applies to you)

☐ Changes in bowel or bladder function
☐ Nausea/ vomiting
☐ Dizziness/ lightheadedness
☐ Difficulty balancing with walking
☐ Swelling without injury
☐ Ringing in ears
☐ Tingling or numbness in arms or legs
☐ Weight loss/ gain
☐ Shortness of breath
☐ Headaches
☐ Changes in appetite
☐ Falls or fear or falling
☐ Vision changes
☐ Fever/ chills/ sweats
☐ Pain at night
☐ Weakness/ fatigue
☐ Difficulty swallowing
☐ Unusual growths
☐ Sexual dysfunction

Have you EVER been diagnosed with any of the following conditions? (Check all boxes that apply)

☐ Cancer (type)
☐ Heart Attack
☐ High blood pressure
☐ Asthma
☐ Lung problems
☐ Osteoporosis/ osteopenia
☐ depression or other mental illness
☐ Seizures/ Epilepsy
☐ Lupus
☐ Scoliosis
☐ Congestive heart failure
☐ MRSA
☐ Rheumatoid arthritis
☐ Stroke
☐ COPD
☐ Anemia
☐ Stomach ulcers
☐ Thyroid disorders
☐ High cholesterol
☐ Lyme Disease
☐ Fibromyalgia
☐ Headaches/ migraines
☐ Heart Disease
☐ Dizziness or fainting
☐ Diabetes
☐ multiple sclerosis
☐ Kidney/ liver problems
☐ Pacemaker placed
☐ Sexual dysfunction
☐ Parkinson's Disease
☐ Bleeding disorder
☐ Emphysema
☐ Osteoarthritis
☐ HIV
☐ Heart surgery
☐ Urinary or bowel incontinence or retention
☐ Chemical dependency (alcoholism, etc.)
☐ Other_____

Do you drink alcoholic beverages? **Y N -** Amount per day _____ Do you smoke tobacco? **Y N –** Packs per day_____.

Do you have / wear the following: Glasses Contacts Dentures Pacemaker Metal implants Hearing aides

List all previous surgeries and dates:_____

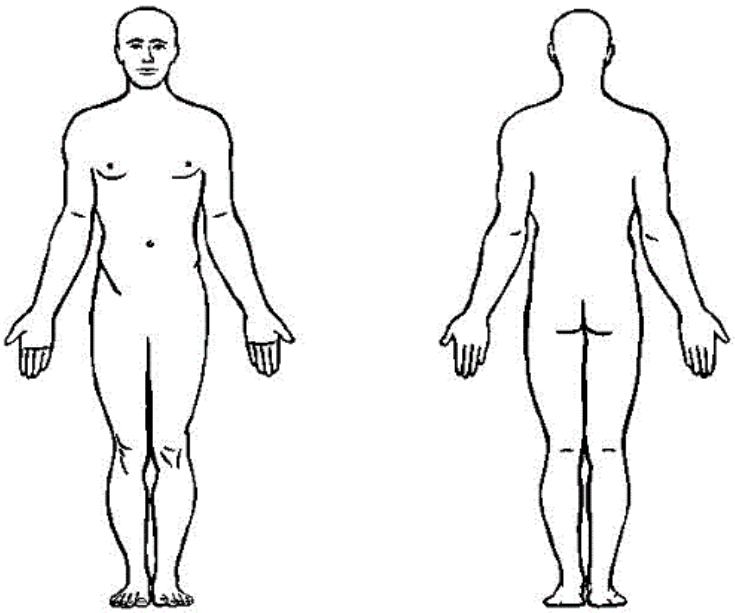
_____

WOMEN: Are you currently pregnant or think that you may be pregnant? YES NO

Please list any current medications with dose and frequency (including herbal supplements, vitamins and any over the counter drugs):

Please list any allergies you have:

Please circle the location of your pain:



Describe pain (please circle): sharp dull aching sore throbbing cramping burning shooting stabbing constant intermittent

To the best of my ability, I have given and included all pertinent medical information

Patient/ Guardian signature:_____Date: _____/_____/_____

Medical history reviewed by physical therapist and used in determining plan of care

Therapist signature:_____Date: _____/_____/_____