



**Grove Andersen
Ghiringhelli PT**

Patient Medical History

Name: _____ Referring Physician: _____

Date of Injury: _____ Date of next Doctors visit for this injury: _____

Have you had surgery for this injury: ____ Yes ____ No Date of Surgery: _____

Are you currently taking any prescription or non prescription medications?: ____ Yes ____ No

Please list all medications you are currently taking, please include dosage: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Numbness or Tingling	_____	_____
Shortness of breath/Chest Pain	_____	_____	Dizziness or Fainting	_____	_____
Coronary artery disease or angina	_____	_____	Bowel or Bladder problems	_____	_____
Do you have a pacemaker?	_____	_____	Weakness	_____	_____
High blood pressure	_____	_____	Weight loss/Energy loss	_____	_____
Heart Attack or Surgery	_____	_____	Hernia	_____	_____
Stroke/TIA	_____	_____	Varicose Veins	_____	_____
Congestive Heart Disease	_____	_____	Allergies	_____	_____
Blood Clot/Emboli	_____	_____	Any pins or metal implants	_____	_____
Epilepsy/Seizures	_____	_____	Joint replacement surgery	_____	_____
Thyroid Disease or Goiter	_____	_____	Neck Injury/Surgery	_____	_____
Anemia	_____	_____	Shoulder Injury/Surgery	_____	_____
Infectious diseases	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Diabetes	_____	_____	Back Injury/Surgery	_____	_____
Cancer or Chemotherapy	_____	_____	Knee Injury/Surgery	_____	_____
Arthritis	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Are you pregnant?	_____	_____
Gout	_____	_____	Do you use tobacco?	_____	_____
Sleeping Problems/Difficulties	_____	_____	If yes how long have you used tobacco?	_____	_____
Emotional/Psychological Problems	_____	_____		_____	_____
Severe or frequent headaches	_____	_____	How often do you use tobacco?	_____	_____
Vision or hearing difficulties	_____	_____		_____	_____

List any other information that would assist us in your care: _____

What are your rehabilitation expectations/goals while in this program? _____

Patient/Guardian Signature: _____ Date: _____



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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

As part of my health care, PRN Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among PRN Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for PRN Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that PRN Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand PRN Physical Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that PRN Physical Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

Spouse/Children: _____

Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

Home Phone Work Phone My Mobile Phone Email

Provide email address or phone number: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of PRN Physical Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

Signature of patient or legal representative

Date

Relationship to Patient

Printed name of patient



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Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.
2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of \$25 based on appointment type.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Grove Andersen Ghiringhelli PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Grove Andersen Ghiringhelli PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Grove Andersen Ghiringhelli PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

Name

Telephone Number

Relationship

6. **MEDICARE PATIENTS:** Have you received any prior physical/occupational therapy this year? (circle) YES NO
Have you received any home healthcare services this year? (circle) YES NO

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person

Date

Printed Name of above

Date



*Grove Andersen
Ghiringhelli PT*

Authorization for Text/Email Reminders

Indicate the types of messages you agree to receive by checking the boxes below. If you select more than one method for a message type, you will receive the message by all of the methods selected.

- Appointment reminders TEXT
- Appointment reminders EMAIL
- On Demand TEXT (allows you to correspond with your therapist for exercise instruction, recommendations and/or advice)

You acknowledge that text alerts will be sent to the MOBILE phone number you provided. Such alerts may include limited personal information and whoever has access to the mobile phone or carrier account will also be able to see this information. Once you enroll, the frequency of text alerts we send to you will vary. You will typically receive text alerts when we have information for you about your therapy prescriptions or other healthcare information. We do not impose a separate charge for text alerts; however, your mobile carrier's message and data rates may apply depending on the terms and conditions of your mobile phone contract. You are solely responsible for all message and data charges that you incur. Please contact your mobile service provider about such charges. The following carriers are supported: AT&T, Sprint, Boost, Verizon Wireless, U.S. Cellular and T-Mobile.

You may opt out of text alerts at any time. To stop receiving text alerts, reply STOP. After you submit a request to unsubscribe, you will receive one final text alert from our clinic confirming that you will no longer receive text alerts. No additional text alerts will be sent unless you re-activate your enrollment.