Confidential Medical History/Evaluation

Name: _____ DOB _____ Date: _____/_____/_____

Occupation:_____ Employers Name_____ Employers Phone #_____

Chief Complaint: _____ Date of Injury/Onset: _____

Location of Injury: ____Work Related ___ Auto Accident ___ Personal Injury Other: _____

Current Symptoms: (Circle all that apply) Pain Numbness Stiffness Weakness Other:_____

Condition: (Circle one) New Acute Chronic Other: _____ Have you had surgery for this condition? Yes No

List any Surgeries and Dates: _____

List any Medications you are currently taking: _____

List any known Allergies: _____

Have you had any Diagnostic testing or Rehabilatation for this injury? ___MRI ___Xrays ___ CT scan ___ Hospitalization _____ Rehab stay Other:_____ Results of testing: _____

(Check YES or NO)	YES	NO
Asthma, Bronchitis or Emphysema	____	____
Shortness of Breath/Chest Pain	____	____
Coronary Heart Disease	____	____
Do you have a Pacemaker	____	____
High Blood Pressure	____	____
Heart Attack/Surgery	____	____
Stroke/TIA	____	____
Blood Clot/Emboli	____	____
Epilepsy/Seizures	____	____
Thyroid Trouble/Goiter	____	____
Anemia	____	____
Infectious Disease	____	____
Diabetes	____	____
Cancer or Chemo/Radiation	____	____
Arthritis/Swollen Joints	____	____
Osteoporosis	____	____
Varicose Veins	____	____
Gout	____	____
Sleeping Difficulties	____	____
Emotional/Psychological Problems	____	____
Bowel or Bladder Problems	____	____
Severe/Frequent Headaches	____	____
Vision/Hearing Difficulties	____	____
Dizziness or Faintness	____	____
Are you pregnant?	____	____

	Mild	Moderate	Severe	Unable
Bending	____	____	____	____
Care for Infirm Family	____	____	____	____
Carrying Groceries	____	____	____	____
Change in Position	____	____	____	____
Climb Stairs	____	____	____	____
Driving	____	____	____	____
Extended Computer Use	____	____	____	____
Feeding (Self)	____	____	____	____
Household Chores	____	____	____	____
Kneeling	____	____	____	____
Lift Children	____	____	____	____
Lifting	____	____	____	____
Pet Care	____	____	____	____
Reading (Concentration)	____	____	____	____
Self Care-Bathing	____	____	____	____
Self Care-Dressing	____	____	____	____
Self Care-Shaving	____	____	____	____
Sexual Activities	____	____	____	____
Sleep	____	____	____	____
Sitting (Prolonged)	____	____	____	____
Standing (Prolonged)	____	____	____	____
Walking	____	____	____	____
Yard Work	____	____	____	____

Sports: _____

Recreational Activities: _____

Other Limitations: _____

Smoking Daily _____ Weekly _____

Exercise Daily _____Weekly_____

Alcohol Consumption: Daily_____ Weekly _____

Other Medical Conditions or Pertinent Medical History: _____

_____

_____

Please sign below that you have reviewed all information above, and it is correct to the best of your knowledge

_____ _____ _____

Signature of Patient/Guardian/Representative Relationship Date

_____ _____

Signature of Evaluating Therapist Date

INFINITY PHYSICAL THERAPY

FINANCIAL AGREEMENT

We want to be sure that each patient understands each part of their treatment program. This includes the financial policies and agreements. To assist you we have developed the following agreement.

1. As a courtesy to you, we will submit your insurance claim for you. Although your insurance carrier is billed, please remember that professional services are rendered and charged to the patient. We cannot accept responsibility for collecting your insurance claim.

2. Many insurance companies including Medicare, pay only a percentage of the treatment charges. We will work with you to verify your insurance coverage and to determine your personal costs.

3. As a patient at Infinity Physical Therapy, you become the responsible party and agree to pay the charges incurred for the therapy treatment. You also assign any payment directly to the facility.

4. Your medical insurance represents a contract between you and your insurance company. If you do not agree with the payment made by your insurance carrier, you should contact them directly. Infinity Physical Therapy is unable to accept responsibility for negotiating any payment or insurance coverage

5. In the event the insurance claim is denied, Infinity Physical Therapy reserves the right to require payment from the patient. Payment arrangements may be made with the business office prior to the beginning of therapy or by making payments at the end of each treatment session

6. A statement will be sent out once a month. Your statement will include all treatments incurred during the previous month.

The undersigned hereby authorizes that payment for the allowed benefits be made to Infinity Physical Therapy

I also authorize any holder of medical information about me to release any needed information to determine benefits payable for the therapy services.

I accept that my signature below indicated that this agreement has been read and accepted.

_____ _____ _____

Signature of Patient/Guardian/Representative Relationship Date

_____

Patient Name Printed

_____ _____

Signature of Therapy Representative Date

INFINITY
PHYSICAL THERAPY

SERVICE AGREEMENT

1. The undersigned herby authorizes Infinity Physical Therapy to administer treatment as necessary and ordered by patient's physician.

2. Infinity Physical Therapy agrees to exercise such reasonable care toward the patient as his/her known condition may require, however, it is in no sense an insurer of his/her safety or welfare and assumes no responsibility for such.

3. It is agreed that if the patient's attending physician (or his designee) is not available in an emergency situation, appropriate intervention will be rendered.

4. The undersigned hereby authorizes the release of medical records to Infinity Physical Therapy. These records will be kept confidential as part of the patient's medical record.

5. Infinity Physical Therapy shall not be responsible for any money, valuables or personal effects brought into the facility.

6. Infinity Physical Therapy has a 24-hour cancellation/scheduling policy. If you miss or cancel an appointment with less than a 24-hour notice, you will be charged a $25.00 fee.

7. For Dry Needling, there will be a charge of $1.00 for up to 10 needles used per session. If 11 or more needles are used per session, then there will be a $2.00 charge.

Signature below indicates that this agreement has been read and any questions have been answered.

_____	_____	_____
Signature of Patient/Guardian/Representative	Relationship	Date
_____	_____	_____
Patient Name Printed	Signature of Therapy Representative	Date

The HIPPA Privacy Rule

Consent for the Use or Disclosure of Health Information for Treatment, Payment or Health Care Operations

I understand that as part of my health care, the Facility and the physician(s) who care for me, originate, and maintain health records by describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer, including Medicare and Medicaid, can verify that services billed were provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that the Facility reserves the right to change its notice and practices and that prior to implementation of those changes, will mail a copy of the revised notice to me.

I understand I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the Facility is not required to agree to the restrictions requested.

Revoke this consent in writing, except to the extent that I revoke my consent, then the Facility will no longer be able to treat me and that I will need to be discharged from the Facility.

Signature below indicates that this agreement has been read and any questions have been answered.

_____	_____	_____
Signature of Patient/Guardian/Representative	Relationship	Date
_____	_____	_____
Patient Name Printed	Signature of Therapy Representative	Date

INFINITY
PHYSICAL THERAPY

APPOINTMENT REMINDER

How would you like to receive our appointment reminder?

Please check one and add your preferred number

_____ HOME _____

_____ CELL _____

_____ TEXT MESSAGE _____

Add (740) 217-3623 to your contacts as

Infinity Appointment Reminder

DO NOT CALL THIS NUMBER BACK

Call clinic directly if you need to make any changes to your appointment

Boardman (330) 629-8834
East Liverpool (330) 386-5252