



Back to Life Physical Therapy

PATIENT INFORMATION FORM

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Best number to reach you) _____ (home/work/cell – circle one)

Phone (Alternate) _____ (home/work/cell – circle one)

Email Address _____

Employer _____ Job Title _____

Birth date _____ Age _____

Emergency Contact Name _____

Emergency Contact Phone _____

Emergency Contact's Relation to You _____

Referring Physician _____

Physician's Diagnosis _____

Primary Physician (if different from above) _____

Brief description of your symptoms _____

Have you had surgery related to the condition for which you are coming to physical therapy? _____

If yes, please list, with dates _____

Were you injured at work _____ Date _____

Were you injured in an Auto Accident _____ Date _____

Patient signature: _____ Today's Date: _____

POLICIES AND CONSENTS

Welcome

The goal of Back to Life is to provide you with precise, effective and compassionate physical therapy. Please take the time to read the following office policies carefully and to then sign the statements of consent.

Financial Policy

The financial responsibility for services rendered is yours. Payment of charges is due at the time of service.

Appointment Policy

You are responsible for scheduling your appointments.

Appointments are scheduled for one hour each. 60 minutes is spent one on one in the physical therapy session. The treatment schedule is booked so that you will not be kept waiting. Failure to arrive at your scheduled appointment time will result in less time available for your treatment.

Appointment cancellations require a minimum of 2 business days notice. In the case of Monday appointments, please call by Thursday, and for Tuesday appointments, please call by Friday.

You will be responsible for the full payment of a session cancelled without 48 hours notice regardless of the reason for your cancellation.

I have read the above policies and agree to comply with them. I authorize release of any information regarding my treatment in this facility to my referring physician.

Patient signature: _____ Date: _____

Consent to receive services: I hereby authorize Amy Selinger, PT, DPT, OCS to render appropriate physical therapy services to me. I recognize and agree that I have the right to refuse treatment or to terminate treatment at any time by notifying Amy Selinger, PT, DPT, OCS. In addition, Amy Selinger, PT, DPT, OCS may terminate services by notifying me of the termination and reason.

Authorization for Emergency Medical Services: In the event of a medical emergency during physical therapy treatment, I authorize Amy Selinger, PT, DPT, OCS to provide or obtain such medical treatment as she deems advisable under the circumstances and I agree to assume sole responsibility for all charges for such treatment.

Patient signature: _____ Date: _____

I have received a copy of this policy _____

PREVIOUS MEDICAL HISTORY

Please indicate yes if you have now, or have previously had, any of the following:

High blood pressure	_____	Pregnancies	_____
Low blood pressure	_____	Depression	_____
Heart disease	_____	Asthma	_____
Cancer	_____	Emphysema	_____
Diabetes	_____	Thyroid disorder	_____

Other medical history (please list) _____

Allergies (please list – if any) _____

Surgeries (please list, with dates - even if they seem unrelated) _____

Musculoskeletal injuries/strains other than those for which you are coming to physical therapy.
(Please list - even if they seem unrelated): _____

Medications (please list) _____

Have you previously experienced the condition for which you are seeking treatment? _____(yes/no).
If yes, please describe what type of treatment you have received (massage, physical therapy, chiropractic, acupuncture or osteopathic care, etc.) and how frequently you have received treatment. _____

Patient signature: _____ Today's Date: _____