Patient Information

Date:_____

Name:_____Date of Birth:_____Age:_____

Address:_____City:_____State:____Zip:_____

Phone Number:(____)_____Email Address:_____

Occupation:_____Presently working? Yes:_____no:_____

Emergency Contact:_____Phone number:_____

Please tell us kindly who referred you to us:_____

Billing Information

Have you provided us with a copy of your insurance card?_____If not please provide us with the following information:

1) **PRIMARY INSURANCE:**_____ID#_____

Primary Subscriber's Name:_____
DOB:_____Group#_____ Employer:_____
Your relation to subscriber: Self:___ Spouse:___ Child:___ Other:___

SECONDARY INSURANCE:_____ID#_____
Primary Subscriber's Name:_____
DOB:_____ Group #_____Employer:_____
Your relation to subscriber: Self:___ Spouse:___ Child:___ Other:___

CHAUX PHYSICAL THERAPY

Pain and Symptoms Status Report

Name:_____Date:_____

1. Please describe your current symptoms:_____

2. When did symptoms start?_____

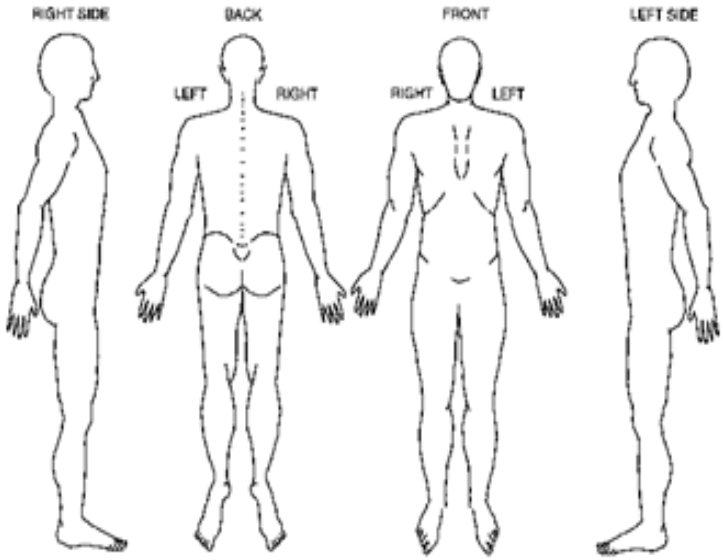
3. How did symptoms start?_____

4. My symptoms are currently: _____Getting Better _____About the same _____Getting Worse

5. Please list any previous treatments for the condition we are seeing you for today:_____

6. Have you fallen in the past 12 months? Yes:_____ No:_____ How many times?_____

7. Have you had imaging studies done for this problem (x-rays, MRI, etc)? Yes:_____ No:_____



Please use these symbols to note symptoms location:
^^ Numbness ** Pins & Needles // Pain

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Circle the number that represents your *average* level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that best represents your *worst* level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please list any allergies:_____

Please list any other current medical conditions:_____

Please provide a list of current medications:_____

Informed Consent for Physical Therapy

Physical therapy involves the use of many different types of physical evaluation and treatment. At Chaux Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy modality or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledged that my treatment program has been explained by Chaux Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Chaux Physical Therapy as outline to me, and I wish to proceed.

_____	_____	_____
Patient Name	Patient Signature	Date

Private Notice

HIPPA AND NOTICE OF PRIVACY PRACTICES

I understand that Chaux Physical Therapy may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I also understand that Chaux Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in Chaux Physical Therapy Notice of Privacy Practices, which is displayed in the reception area and a copy of which is available upon request.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. By signing this form, I am acknowledging receipt of the *Notice of Privacy Practices* for Chaux Physical Therapy.

Name of Patient (Print Clearly)

Signature of Patient Date

CHAUX
PHYSICAL THERAPY

Missed Appointment Policy

We appreciate you greatly as our patient and strive to accomplish optimal results and success for you. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment within the same week. We reserve the right to charge you a $75 no-show fee for cancelling an appointment without 24-hour notice or a no-show to a scheduled appointment.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. Your physician will be informed that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Late Arrival Policy

In consideration of other patients, your appointment time cannot be extended if you do not arrive on time. The therapist will determine if there is sufficient time to render quality care in the time remaining for your scheduled appointment. If you are more than 10 minutes late, the therapist may determine that there is insufficient time to provide proper treatment, and you may be charged our $75 missed appointment fee.

_____	_____	_____
Patient Name	Signature	Date

Precautionary Coronavirus Liability Release Form

Due to the outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitization and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- New widespread muscle pain
- Headaches
- Loss of taste & smell
- Fatigue
- Dry cough
- Difficulty breathing
- Chills
- Nausea or vomiting
- Diarrhea

I, _____ agree to the following:
I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
I affirm that I, as well as all household members, have not been diagnosed with COVID19 within the last 30 days.
I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.
I understand that this business and my physical therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the physical therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19.

Your Physical Therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitization protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Patient Signature: _____ Date:_____