Tyler PHYSICAL THERAPY & PILATES

Who may we thank for referring you to us?

Doctor _____ Friend _____

Family Member _____ Website _____

Other _____

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Address	City/State	Zip Code
Home Phone	Cell Phone	DOB
Email Address	Gender (select one) Male____ Female____ Non-Binary____	
Primary Doctor	Doctor's phone number	
Employer	Occupation	
Emergency Contact	Emergency Contact Number	
Appointment Reminder Preference: Please select an option to the right of this box	PHONE____ EMAIL____ NO REMINDER____	

INJURY INFORMATION

Employment Injury?	YES	NO	If yes, date _____
Auto Accident?	YES	NO	If yes, date _____
Other Accident?	YES	NO	If yes, date _____
Surgery?	YES	NO	If yes, date _____

The above information is true to the best of my knowledge. I consent to treatment for Physical Therapy. I authorize my insurance benefits to be paid directly to Tyler Physical Therapy. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize Tyler Physical Therapy to release an information required to process my claims and secure the payment of benefits.

Patient/Guardian Signature: _____ Date: _____

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CONFIDENTIAL MEDICAL QUESTIONS

Have you ever experienced any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Anemia/ Blood disorder			Stroke			Sensitivity to Ice		
Arthritis			Falls			Sensitivity to Heat		
Bowel/Bladder problems			Gynecologic Conditions			Lung Disorder		
Cancer			Headaches (+1 per week)			Neurological Disorder		
Depression			Hearing Problems			Osteoarthritis		
Diabetes			Hernia			Osteoporosis		
Dizziness			Kidney Problems			Rheumatologic Disorder		
Arterial blockage of legs			Liver/Kidney Conditions			Thyroid condition		
Deep Venous Thrombosis			Head Trauma			Vision condition		
Heart Disease			Fractures			Pacemaker		
High Blood Pressure			Seizures			Metal Implants		

CURRENT MEDICATIONS

Name	How Much/How Often
1.	
2.	
3.	
4.	
Do you smoke? YES NO	Alcohol Consumption: Daily Weekly Occasionally Rarely Never
Please list any allergies you have:	
Are you pregnant: YES NO	Have you experienced recent unplanned weight loss? YES NO

Patient/Guardian Signature: _____ Date: _____

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PAIN SCALE

Circle the number that indicates your pain

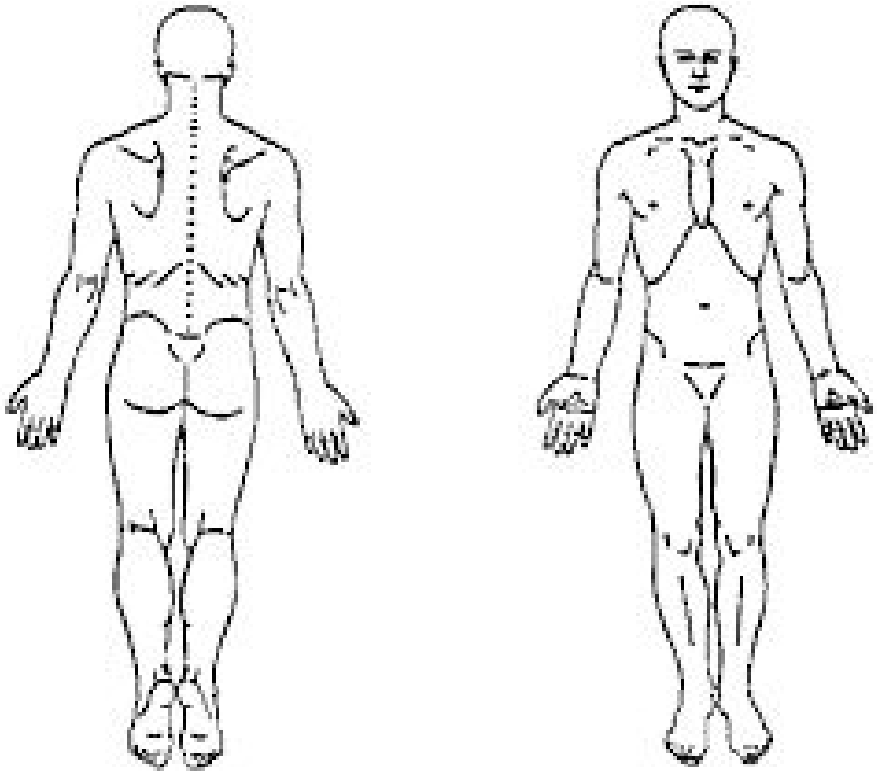
0 = no pain at all

10 = need to call 911/emergency pain

- Today? 0 1 2 3 4 5 6 7 8 9 10
- Worst? 0 1 2 3 4 5 6 7 8 9 10
- Least? 0 1 2 3 4 5 6 7 8 9 10

Which word best describes the quality of your discomfort??

Aching Stabbing Numbness Dull Burning Pins and Needles



Please circle the location(s) of your pain/discomfort

Patient/Guardian Signature: _____ Date: _____

Tyler PHYSICAL THERAPY & PILATES

CONSENT TO TREAT AND PRIVACY POLICY

Financial Responsibility

I understand that I must furnish my insurance cards if I would like my insurance to be billed for the services performed at Tyler Physical Therapy. If my insurance changes during treatment, and I would still like my insurance to be billed, I must notify the front desk as soon as possible to avoid delays in my claims.

I agree to pay my copays at the time of service. If for any reason there is a balance on my account, I will pay promptly upon receipt of statement.

I understand that the staff has provided me with an estimate of my financial responsibilities, and I am responsible for any charges that I may incur outside of that estimate. I understand that although I have requested Tyler Physical Therapy to bill my insurance on my behalf, that I am responsible for my account. The insurance information provided to me is not a guarantee of coverage. If the coverage provided by my insurance company is not accurate, or changes, I am responsible for payment of services.

Consent to Treatment

I consent to rehabilitation and incidental medical services at Tyler Physical Therapy. I understand the expected benefits, possible risks, side effects, complication and discomforts of my rehabilitation. I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training and special procedures such as taping. I understand that it will be explained to me the purpose of the therapeutic procedures prior to receiving the treatment and that I am able to stop treatment if I feel any discomfort or pain.

Release of Medical Information

I authorize the release of any personal health information required for treatment, payment, evaluating the quality of service provided and any administrative operations. The patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities which have records necessary for proper evaluation and treatment of patient. All other uses and disclosure will be made only with my written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

I certify that I have read and understand the above statements

Patient/Guardian Signature: _____ Date: _____

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Patient Name (PRINTED):_____

Patient Responsibility

In order to avoid a penalty, requests to cancel or reschedule appointments must be made at least 24 hours prior to the start time of your originally scheduled appointment ***(with either voicemail or email confirmation)*** Each patient will, however, be allowed ONE free cancellation/no show for the duration of their care. Regardless of circumstance, each subsequent cancellation/no show that does not meet the above stated 24-hour requirement will incur a $60 fee. The patient is wholly responsible for this fee.

In order to continue to provide our standard of care of seeing just one patient one on one for an hour, we must value our therapists' time and resources. By signing this document, you acknowledge that you understand and agree to the terms of our Cancellation Policy.

If you should have any questions regarding our policy, please discuss with the front office staff.

Printed Name _____ Signature _____
Date_____

Consent for Treatment of a Minor

As a parent and/or legal guardian, I authorize Tyler Physical Therapy to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

Patient/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Tyler Physical Therapy's Legal Duty – Tyler Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information: Tyler Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care we provide. For example, we may use your personal health information to contact you for appointment reminders, information about treatment alternatives, or to explain other health-related benefits that could be of interest to you.

Tyler Physical Therapy may also use or disclose your health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Tyler Physical Therapy may change its policy at any time. When changes are made a new Notice of Information Practices will be posted in the front office, patient exam area and will be provided to you on your next visit. You may also request an updated copay of our Notice of Information Practices at any time.

Patient's Individual Rights: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or operations. You may request in writing that we do not use or disclose your personal health information for treatment, payment, and operations except when specifically authorized by you, when required by law or in emergency circumstances. Tyler Physical Therapy will consider all such requests on a case-by-case basis but Tyler is not legally required to accept them.

Concerns and Complaints: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our front office at the phone number listed below. You may also send a written complaint to the US Department of Health and Human Services.

Tyler Physical Therapy & Pilates (818)369-7700

Patient/Guardian Signature: _____ Date: _____