DIAMOND
PHYSICAL THERAPY

Real Results For Real People.

CONSENT FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Diamond Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Diamond Physical Therapy. I understand that diagnosis or treatment of me by Diamond Physical Therapy may be conditioned upon my consent as evidenced by my signature or this document I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Diamond Physical Therapy is not required to agree to the restrictions that I request, the restriction is binding on Diamond Physical Therapy.

I have the right to revoke this consent. In writing, at any time, except to the extent that Diamond Physical Therapy has taken action in reliance on this consent. My "protected health information" means health information, including demographic information collected, from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Diamond Physical Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Diamond Physical Therapy. The Notice of Privacy Practices for Diamond Physical Therapy is also provided in the reception area. This Notice of Privacy Practices also describes my rights and Diamond Physical Therapy's duties with respect to my protected health information.

Diamond Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

Signed: _____ Date: _____/_____/_____

If you are not the patient, please specify your relationship to the patient: _____

I give permission to share appointment, billing or medical information with the person(s) named here:

_____

Diamond Physical Therapy

PATIENT MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. All information is considered confidential. Thank you. Please print clearly.

Name (Printed): _____ Age: _____ Occupation: _____
(Last) (First)

What body part(s) are we seeing you for? _____Have you been seen for this body part? YES NO

Have you had surgery for this body part? YES NO If yes, when? _____/_____/_____

Have you had any other surgeries we should be aware of? YES NO

If yes, where & when? _____/_____/_____ _____

Are you currently taking any prescriptions or non-prescription medication for *this* body part? YES NO

Check all that apply & write down dosages:

_____Aspirin_____ _____Norco_____ _____Celebrex_____ _____Flexeril_____

_____Vicodin_____ ____Tylenol_____ _____Ibuprofen_____ _____Medrol Dose Pack_____

Are you taking any other prescription medication for any other reason and please list them and for what condition:_____

_____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	EMG/NCV	_____	_____
Neurologist	_____	_____	Myelogram	_____	_____
Orthopedist	_____	_____	Emergency Room Care	_____	_____
General Practitioner	_____	_____	CT scan	_____	_____
Occupational Therapy	_____	_____	MRI	_____	_____
Physical Therapy	_____	_____	X-rays	_____	_____

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

	YES	NO		YES	NO
Asthma, bronchitis, emphysema	_____	_____	headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Vision/hearing difficulties	_____	_____
Coronary disease or angina	_____	_____	Dizziness/fainting	_____	_____
Heart attack or surgery	_____	_____	Weight loss/ energy loss	_____	_____
Do you have a pacemaker?	_____	_____	Hernia: if yes, where? _____	_____	_____
High blood pressure	_____	_____	Allergies	_____	_____
Stroke/TIA	_____	_____	Any joint/metal implants	_____	_____
Blood clot/emboli	_____	_____	Joint replacement	_____	_____
Epilepsy/seizures	_____	_____	shoulder injury/surgery	_____	_____
Anemia	_____	_____	elbow/hand injury, surgery	_____	_____
Infectious disease	_____	_____	Neck/back injury, surgery	_____	_____
Diabetes Type1 Type2	_____	_____	Knee injury, surgery	_____	_____
Cancer/kind _____	_____	_____	Numbness/tingling in hands or feet	_____	_____
Chemotherapy/radiation	_____	_____	Leg/ankle injury/surgery	_____	_____
Arthritis/joint pain	_____	_____	Are you pregnant	_____	_____
Osteoporosis	_____	_____	Do you smoke	_____	_____
Sleeping problems/difficulties	_____	_____	Difficulty urinating	_____	_____
Thyroid condition	_____	_____	Night pain	_____	_____

HAVE YOU FALLEN IN THE PAST 12 MONTHS? YES NO

WHAT IS YOUR PAIN AT WORST IN THE LAST WEEK? 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR PAIN LEVEL AT BEST IN THE LAST WEEK? 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR PAIN LEVEL RIGHT NOW? 1 2 3 4 5 6 7 8 9 10

Patient or responsible party signature: _____ Date: _____/_____/_____

I have reviewed this information with the patient

THERAPIST (PRINTED): _____ THERAPIST (SIGNATURE): _____

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and the gain of your physical abilities is something that everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

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.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require **24 hour notice.** In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hour notice or no-show to a scheduled appointment, we reserve the right to charge you a **$25.00 fee.**

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

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: _____

Date: _____/_____/_____

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PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: M/F

Address: _____

Home Phone: (_____) _____—_____—_____ SS#_____- _____- _____

E-mail: _____

Employer Name: _____Employers Phone Number (_____) _____

Employer Address: _____
(Street) (City/State/Zip)

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____Relationship to Patient: Self Spouse Parent

Address: _____Phone Number: _____

Who to call for an emergency:

Name:_____ Relationship: _____

Home Phone: (_____) _____—_____ Cell Phone: (_____) _____—_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? YES NO

IF YES, PLEASE NOTIFY THE RECEPTIONIST

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REQUEST FOR MEDICAL INFORMATION

Date: _____/_____/_____ Requested by: _____

Physician Name: _____

Physician Fax #: (_____) _____--_____

Consent for the release of _____report(s)

For: (patient print name): _____

I _____, hereby give consent for the release of medical information to Diamond Physical Therapy. Please fax to 847-854-0197.

Patient Signature: _____

Relationship to patient: _____

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This is to acknowledge that I understand the treatment I receive here will be a billed service. I am ultimately responsible for payment.

_____ _____

Patient Signature Date

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Credit Card on File Agreement

I authorize Diamond Physical Therapy to keep a credit card on file to satisfy my financial obligations as defined by Diamond Physical Therapy's Patient Financial Agreement.

I understand that Diamond Physical Therapy is utilizing the latest standards in card data security and HIPAA compliance. Card data being stored is encrypted, tokenized and stored off-site in a secure vault trusted by many fortune 500 companies.

I understand that Diamond Physical Therapy will automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Diamond Physical Therapy of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Patient name (please print): _____

Patient Signature: _____

Patient Date of Birth: _____/_____/_____

Last 4 digits of Credit Card to be put on file: _____

Expiration Date: _____