Complete Physiotherapy, Inc.

New Patient Information

Today's Date:_____

Name: _____ Home Phone: (___) _____

Address: _____ Cell Phone: (___) _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Age: _____ Birthdate: _____/_____/_____ Male/Female

Social Security #_____

Employer: _____ Work Phone: (____) _____

Name of Spouse, if applicable: _____

Spouse Employer: _____Work Phone: (____) _____

Emergency Contact: _____

Relationship: _____Phone: (____) _____

If Patient is a Minor, Responsible Party: _____

Primary Care Physician: _____ Phone: (___) _____

Referral Source:

☐ Physician: _____ Phone: (____) _____

☐ Other: _____

595 Chapel Hills Dr., Suite 145 • Colorado Springs, CO 80920-1024
Phone: (719) 434-7340 • Fax: 719-426-9857
www.completephysiotherapy.net

Complete Physiotherapy, Inc.

Policies

1. I understand that everyone's time is valuable. My physical therapist will strive to keep appointments on schedule and appreciates promptness and dependability on my part. Complete Physiotherapy reserves the right to charge for appointments canceled or broken without 24 hours notice. In the event that two scheduled appointments are missed without 24 hours notice, future appointments may be canceled by Complete Physioworks. Routine reporting to Workman's Compensation includes information on any missed appointments.

2. I hereby authorize Complete Physiotherapy to release any information regarding any illness, injury, medical history, treatment or copies of medical records to any insurance company that I have listed on the patient information form.

3. I hereby authorize the release of medical information and request payment to Complete Physiotherapy for any medical benefits due me under the terms of my insurance policy for services rendered.

4. I understand that I am responsible for the portion of the amount billed that my insurance does not pay (co-pay, co-insurance or deductible). Payment is due at the time services are rendered.

5. I understand that insurance is an agreement between my insurance company and myself and the ultimate responsibility for payment of professional services remains with me. Any questions I have regarding my coverage should be directed to my insurance company. If, for any reason my insurance does not pay, I am responsible for payment of services rendered; this includes auto insurance. If, for any reason my insurance company deems services are not related to my motor vehicle accident, I will be responsible for payment of these services.

6. Any insurance payment received in excess of my account balance will be refunded.

7. I understand that my therapists' schedule may be booked several weeks out and it is my responsibility to make sure I have scheduled appointments. When appointments are not available, I will be put on a cancellation list. The Complete Physiotherapy staff will make every effort to accommodate my appointment request(s), but there is no guarantee that there will be cancellations.

I verify that I have read and agree to abide by the above policies.

Date: _____ Patient Signature: _____

Complete Physiotherapy Witness: _____

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General Explanation of and Consent to Physical Therapy Treatment

Thank you for choosing Complete Physiotherapy. Your physical therapist will do everything in his or her power to assist in resolving your condition. Before we get started, it is important for you to have an understanding of what your treatment will involve.

The physical therapy method practiced at Complete Physiotherapy is referred to as Orthopedic Manual Therapy. This is a specialized form of physical therapy utilized to treat musculoskeletal pain and dysfunction. The techniques will be applied to specific areas of the body to affect a therapeutic response. This is designed to result in improved mobility and a decrease in pain, though some temporary soreness can be expected as the body responds to musculoskeletal changes. At times, musculoskeletal soreness can actually be a very good sign that your body is changing over time.

The manual therapy techniques involve the therapist placing his or her hands on various parts of the body including, but not limited to, the head, neck, back, chest, stomach, pelvis (front and back), arms and legs. This is necessary for a thorough evaluation and treatment of your condition. Please notify your therapist if you have any questions or concerns regarding your treatment.

1. I understand the purpose of the care and reasonable alternative forms of therapy, risks of the recommended and alternative care, and the risks of foregoing this care have been fully explained to me and are understood by me, and that I may discontinue treatment or revoke this consent at any time.

2. I recognize the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guarantee has been or can be made regarding the likelihood of success or outcome of any therapy.

3. I have read the above and I certify that I have had an opportunity to discuss the contents herein to my satisfaction. By signing below, I am hereby requesting and consenting to physical therapy.

Date: _____ Patient: _____

Complete Physiotherapy Witness: _____

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Patient Information Consent

I have read and fully understand Complete Physiotherapy's *Notice of Patient Information Practices.* I understand that Complete Physiotherapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative purposes related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative purposes if I notify the practice. I also understand that Complete Physiotherapy 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 personal health information for the purposes as noted in Complete Physiotherapy's *Notice of Patient Information Practices*. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Patient Signature

_____

Date

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Designated Individuals Authorization

I, _____, hereby authorize the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Medical Information Release

I, _____, hereby release all medical information to Complete Physiotherapy as it pertains to my treatment at Complete Physiotherapy.

_____
Patient Name

_____
Patient Signature

_____
Date

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WWW.COMPLETEPHYSIOTHERAPY.NET

Complete Physiotherapy, Inc. Patient Medical History Form

Name: _____ Date: _____

Last Day Worked Due to this Injury (if applicable): _____ Date Returned to Work after Injury (if applicable):_____

Is this related to an auto accident? YES NO Is an Attorney involved in this case? YES NO

Have you had Surgery for this Injury? YES NO Number of Surgeries: 1 2 3 4 Other: _____

Type of Surgery: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications: Yes No (Please List Below)

Anti-Inflammatories	Yes	No	_____
Muscle Relaxers	Yes	No	_____
Pain Medication	Yes	No	_____
Other	Yes	No	_____

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

	YES	NO		YES	NO
Chiropractor	____	____	Primary Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Acupuncture	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room Care	____	____	X-Rays	____	____

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

	YES	**NO**		**YES**	**NO**		**YES**	**NO**
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____	Anemia	____	____
Shortness of Breath/Chest Pain	____	____	Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____	Gout	____	____
Cancer/Chemotherapy/Radiation	____	____	Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____	Hernia	____	____
Bowel or Bladder Problems	____	____	Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	____	Osteoporosis	____	____
Vision or Hearing Difficulties	____	____	Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____	Blood Clot/Emboli	____	____
Leg/Ankle/Foot Injury/Surgery	____	____	Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____	Varicose Veins	____	____
Any Pins or Metal Implants?	____	____	Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____			

Please list any additional information that would assist us in providing you care?

_____

_____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

Based upon your awareness of your diagnosis, what are your expectations/goals while in this program?

_____

Patient/Guardian Signature: _____ Date: _____

Therapist Signature:_____ Date: _____

Complete Physiotherapy, Inc

No Show and Late Cancellation Policy

We believe strongly in quality of care and do not double book appointments. For these reasons, no shows will incur a charge for the full private pay rate* for each missed visit.

In the event of a cancellation with **less than 24 hours notice**, we will strive to schedule someone else in that appointment time. If we are unable to do so, you will be charged the full private pay rate*.

In the event of two (2) no shows or late cancellations, we reserve the right to cancel all future scheduled appointments and will notify you of this course of action. Routine reporting to Workers Compensation includes information on any missed appointments.

We care about the wellbeing of our patients, and thus, will waive this policy in the event of inclement weather or emergency situations that pose a risk to your or our safety.

I realize that in making an appointment with Complete Physiotherapy, Inc. I am making a commitment to attend the appointment as this is a time reserved exclusively for me. I also agree to abide by this policy and accept responsibility for all appointments I choose to schedule.

***$140 Cash/Check or $150 Credit/Debit Card**

_____ _____

Signature Printed Name

_____ _____

Witness Date

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