

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: _____

COMPLETE PHYSIOTHERAPY, INC.

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

COMPLETE PHYSIOTHERAPY, INC.

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

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.

***\$107 Cash/Check or \$110 Credit/Debit Card**

Signature

Printed Name

Witness

Date