WELCOME TO DECATUR PHYSICAL THERAPY & SPORTS MEDICINE!

(Please complete **ALL** information)

TODAY'S DATE: _____

FIRST NAME: _____ M: _____ LAST: _____

STREET ADDRESS: _____

CITY: _____ ST: _____ ZIP CODE: _____

PREFERRED NAME: _____EMAIL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #_____ SEX: M ☐ F ☐

HOME PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

WORK PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

CELL PHONE # _____ OKAY TO CONTACT + LEAVE A MESSAGE? ☐ YES ☐ NO

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____ BEST PHONE # _____

REFERRING PHYSICIAN: _____ PHONE: _____

OFFICE LOCATION: _____

EMPLOYER: _____ OCCUPATION: _____

I certify that the above information is true and correct to the best of my knowledge. I will notify Decatur Physical Therapy immediately of any changes in my status.

Signature: _____ Date: _____

Responsible Party: (parent, guardian, etc.):_____

Address (if different):_____

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INFORMED CONSENT

Conditions of, and Consent for Treatment: I hearby request and authorize Decatur Physical Therapy to perform therapy on me. I understand that I am a patient of Cecil Anderson or Charles Owen. I consent to treatment, which will include evaluation/assessment and treatment.

The term "informed consent" means that the potential risks and benefits of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment recommendations for my condition.

Cooperation with Treatment: I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No Guarantees: I understand that Decatur Physical Therapy and my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with his opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Potential Risks: I understand that my physical therapy treatment may cause temporary minor soreness or bruising, or an aggravation of my existing injury. If any adverse side effects occur during the course of treatment, I will consult my physician.

Potential Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities as well as decreased pain and discomfort, and knowledge about managing my condition.

Physical Therapists: I understand that Cecil Anderson and Charles Owen are licensed physical therapists in the state of Georgia. I understand that their experience, training and educational background is limited to that required of their profession. As a result, they do not and cannot provide medical care, oversight or supervision.

COVID-19 Policy: I understand the policies and procedures that Decatur Physical Therapy has instituted to minimize the possibility of my exposure to the coronavirus. I agree that I will call the office before visiting if I am unwell in any way, including having a fever, cough, cold symptoms, body aches, fatigue or if I have had contact with someone who has coronavirus. I agree to wear a mask in the office.

COVID-19 Risks: Although Decatur Physical Therapy has put in place policies and procedures to promote the safety of patients, I understand that they cannot guarantee that I will not be exposed to Coronavirus/COVID-19. I have discussed the benefits of therapy and the attendant risks with my physician or physical therapist and have made an informed decision to seek physical therapy at Decatur Physical Therapy.

I certify that I have read the contents of this document. I understand the basic nature of the procedure, the risks involved, and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Signature: _____ Date: _____

Therapist Signature: _____Date: _____

PATIENT MEDICAL HISTORY + GENERAL HEALTH INFORMATION

NAME: _____ AGE: _____

Please describe any other orthopaedic or musculoskeletal injuries/problems:

_____

_____

List any other past surgeries + hospitalizations and dates:

_____

_____

Are there any other medical conditions that your PT should know? If yes, please describe:

_____

_____

Do you have any metal implants (plates, screws, staples)? ☐ YES ☐ NO

Do you have a pacemaker and/or a defibrillator? ☐ YES ☐ NO

Do you smoke cigarettes, a pipe or chew tobacco? ☐ YES ☐ NO

Have you had any recent lab work recently? ☐ YES ☐ NO

If yes, please explain when, where + results: _____

_____

Have you had physical therapy before for other problems? ☐ YES ☐ NO

If yes, where + when? _____

Please list all medications you are taking **NOW** (including prescriptions, over-the-counter, vitamins, herbs + natural/homeopathic medicines) with dose + frequency.

_____

_____

_____

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Have you ever been diagnosed or treated for any of the following?

- ☐ Cancer
- ☐ COVID-19
  COVID-19 VACCINATED ☐ Y ☐ N
- ☐ Heart Disease
- ☐ Angina/Chest Pain
- ☐ Shortness of breath/Asthma
- ☐ Stroke
- ☐ Kidney Disease/Infection
- ☐ Insomnia
- ☐ Hypertension/High Blood Pressure
- ☐ Diabetes
- ☐ Hepatitis/Liver Disease
- ☐ Emphysema
- ☐ Migraine Headaches
- ☐ Ulcers/Stomach Problems
- ☐ Allergies
- ☐ Depression
- ☐ Recent Weight Loss/Gain
- ☐ Epilepsy/Convulsions
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Chills/Night Sweats

When do you return to see your physician? _____

+ FOR WOMEN ONLY +	
Are you pregnant?	☐ YES ☐ NO
Are you planning to become pregnant in the immediate future?	☐ YES ☐ NO
How many pregnancies have you had?	_____
Are you menopausal?	☐ YES ☐ NO
Are you taking estrogen/hormone replacement therapy?	☐ YES ☐ NO

I certify that the above information is true and correct to the best of my knowledge. I will notify Decatur Physical Therapy immediately of any changes in my status.

Signature: _____ Date: _____

APPOINTMENT CANCELLATION & NO-SHOW POLICY

Thank you for selecting Decatur Physical Therapy for your treatment. We take our obligation to provide the highest quality service very seriously. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one treatment. Appointments are in high demand, and we maintain a waiting list of people who need care.

- An appointment missed or cancelled without a 24 hour notice or arriving for an appointment too late to complete treatment is considered a "no show".
- A "no show" will be recorded in the patient's chart. There will be no charge to the patient for the first event. Any additional "no shows" will result in a **fee of $50 charged to the patient**, which must be paid at your next appointment.
- Missed appointment fees are not covered by insurance, attorneys or liens. You are personally responsible for the fee.
- To cancel appointments, please call **404-297-9315** at least **24 hours prior** to your scheduled appointment. If you do not reach one of us, you may leave a detailed message on voice mail.

FINANCIAL ACKNOWLEDGEMENT

Decatur Physical Therapy is committed to caring for our patients. If you have medical insurance, we will help you get the most out of your insurance benefits. To reach this goal, we need your help.

- Our staff will help you by sending in an insurance claim form, as payment for your therapist's care.
- We have made every effort to determine if the care you receive here will be covered by your insurance company, to understand the benefit they will pay, and to communicate that clearly to you. We rely on information from you and your insurance company to estimate your financial responsibility. We are not responsible for errors in that information.
- It is important to understand that payment for services is due when you receive treatment, unless payment arrangements have been made.
- Your insurance plan is a contract between you, your employer and the insurance company. We have nothing to do with that contact. Please call your insurance company if you have questions about your benefits.
- All services may not be covered by all insurance contracts. We have made every effort to insure that we only provide services that are covered by your insurance company. If your doctor has ordered services that we know are not covered, we will advise you. You are responsible for charges not covered by your insurance company.
- If your insurance requires that you have a referral from your primary care doctor, you must insure that your insurance company has that referral on file.
- If your check is returned, you will have to pay a returned check charge of $35, which is what our bank charges us, in addition to any fees that your bank may charge you.
- Our fees are within the range most insurance companies accept, they are considered usual, customary and reasonable by most companies.
- **We know financial problems can affect the on-time payment of your account. If this happens, call us at 404-297-9315 for help.**

I have read the above policies completely. I agree to all of the terms and understand that if I violate these policies it may result in the termination of my doctor/patient relationship.

Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS

I hereby instruct _____ **Insurance Company** to pay Decatur Physical Therapy & Sports Medicine, electronically or by check.

- If my insurance policy prohibits direct payment to the physical therapist, I hereby instruct and direct you to make the check payable to me and mail it to DPT at the above address.
- For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS + BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Decatur Physical Therapy & Sports Medicine, and I have agreed to pay in a current manner, any balance of said professional service charge over and above this insurance payment.
- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
- I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

CHARGES FOR SUPPLIES + ACCESSORIES

In the course of therapy, you may require therapy items or supplies to perform treatments or home exercises. Your insurance does **NOT** cover supplies and the patient much purchase them. Our office acquires supplies at the best price possible and sells them for a nominal price to cover the item and shipping costs. Examples of necessary supplies include Electrodes for Electrical Stimulation, which is a commonly performed therapeutic treatment (for your safety, our office dedicates a set of electrodes to you exclusively. Cost is $5.) To perform exercises at home, examples include an Exercise Band ($3), Theraputty ($5), a set of Loop Bands ($10) or a Shoulder Pully ($15).

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our commitment is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interest, it may be necessary to share information with our health care providers, insurance companies, billing services, family members and others involved in your case. We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

- I have read and understand the above notice of Privacy Practices
- I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact you to obtain a current copy of the Notice of Privacy Practices.

I have read the above policies completely. I agree to all of the terms and understand that if I violate these policies it may result in the termination of my doctor/patient relationship.

Signature: _____ Date: _____