Intake Form

Name: _____

Mailing Address: _____

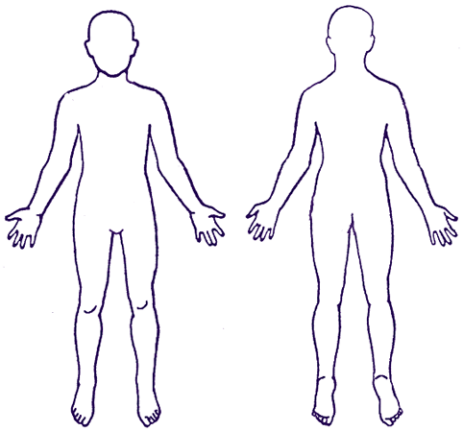
Phone: _____ Email address: _____

Employer: _____Work duties: _____

Emergency Contact: _____ Emergency Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Below, please circle, color in, x pain/symptom location and rate current intensity 0-10 beside it:



Please briefly describe your symptoms: _____

_____

_____

Nature of pain/symptoms. Please check all that apply:

__sharp __constant __throbbing __periodic __dull
__occasional __aching __other (please describe)_____

_____

On the line below, rate the intensity of your pain 0-10 (0 is no pain and 10 is "I need to go to the hospital"):

Best: ____ Current: ____ Worst: ____ When did you first notice symptoms? _____

Any previous injury to this area? _____ If so, when? _____ How many recurrences? _____

What increases your pain? _____

What decreases your pain? _____

Please provide any current or past Medical/ Surgical history (surgery dates if known): _____

_____

_____

Check if yes: ___ Pacemaker ___Mesh ___Hernia ___Currently pregnant

What activities are you having trouble doing? _____

Please list any medications including nutritional supplements you are taking: _____

_____

How did you hear about me? _____

I give my consent to be evaluated and treated by a licensed physical therapist for my condition. I understand that I will receive an initial evaluation which may be followed by one or several treatment sessions.:

_____

Print Patient's Name

_____ _____

Patient or Authorized Representative's Signature Date

What you might expect during your Physical Therapy evaluation and treatment may include but are not limited to the following:

Initial Evaluation

- Complete paperwork
- Discussion regarding current and past injuries, medical history, surgical history, goals
- Assess strength and range of motion
- View posture in standing to identify abnormalities, asymmetry, tightness (may touch a variety of muscles throughout the body to assess for imbalances and tightness, will touch bony landmarks at the hips/ shoulders/ back to assess symmetry and movement)
- Posture will be assessed from all four views of your body: front, back, and both sides
- Forward bend to look at motion of the pelvis and the spine with therapist's hands on the hips/ pelvis/ back.
- Assess movement patterns with functional activities including sit to stand and stand to sit transitions, walking, squats, standing balance, and other possible tests and measures
- Tissue mobility assessment
- Sensation testing which can consist of light touch or deep pressure along the neck, arms or legs. Abdomen may be assessed if determined necessary
- Neurological, cardiopulmonary, skin integrity testing is possible

Treatment

- Treatment can consist of exercises for strengthening, stretching, balance training, neuromuscular retraining or manual therapy
- Manual therapy can consist of joint mobilizations, tools adding pressure along the skin such as graston technique or other varieties, trigger point release, soft tissue mobilization or John Barnes' myofascial release
- Myofascial release has best results if the therapist is able to apply pressure directly to the skin. Please wear appropriate clothing: tank top and shorts are best. Clothing will be moved out of the way as appropriate to reach the areas necessary for treatment. Myofascial release consists of gentle sustained pressure or pulls to areas of the body that are hard, hot, tender or are not moving properly. The body is interconnected. Although your pain may be in a specific area, we will need to address other areas of the body including but not limited to the pelvis as these imbalances of the body can be the source of your pain. Your therapist will need to apply pressure to a variety of places throughout the body, with the exception of your genitals and nipples (patients with breast involvement may differ). Your therapist will make you aware if she is needing to apply pressure near the breasts or genitals. You may ask your therapist to ease up pressure, or stop at any point in time. Please ask if you have any questions.

_____

Print Patient's Name

_____ _____

Patient or Authorized Representative's Signature Date

Attendance, Cancellation and Late Policy

I strive to provide you with the best possible care for you as an individual. Your treatment time is reserved for your 1:1 care. In order for you to receive maximum benefit from your therapy treatments I ask that you consider the following:

- Please arrive early enough to begin your appointment on time. If you arrive late, the full rate will be charged and your appointment will end at the scheduled time.
- If you are unable to make your appointment, I kindly ask that you notify me by phone or email no later than 24 hours prior to your appointment. You may leave a message on the voicemail.
    - Phone: 704-360-0235
    - Email: ashley@ahealingfriend.com
- If I do not receive the requested advanced notice, you will be required to pay a cancellation fee prior to attending your next scheduled appointment.
    - Cancellations made within 24 hours and same day no-shows will be charged to you for 100% of the cost of your treatment
- In order to achieve maximum benefit, I ask that you do your best to perform your home exercise program as prescribed.

I look forward to working with you and helping you receive the best results from your therapy treatment.

_____

Print Patient's Name

_____ _____

Patient or Authorized Representative's Signature Date

HIPAA COMPLIANCE PATIENT CONSENT FORM

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed this notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment.

By signing this form, you consent to my use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

___Protected health information may be disclosed or used for treatment, payment, or healthcare operation

___The practice reserves the right to change the privacy policy as allowed by law

___The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

___The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

May I phone you to confirm appointments? **Yes No**

May I leave a message on your answering machine at home or on your cell? **Yes No**

May I leave a message at your employment? **Yes No**

May I email to your specified email address personal private health information including but not limited to treatment recommendations, relevant scientific articles and medical forms? **Yes No**

May I discuss your medical condition with any member of your healthcare team? **Yes No**

_____

Patient's Signature

CONSENT FOR TREATMENT

I, _____, (please print name) am voluntarily seeking Physical Therapy treatment from Ashley Elizabeth Friend and give permission to provide treatment to me in accordance with the information, explanations and recommendations she provides me. I also understand that I am responsible for all charges.

_____
Print Patient's Name

_____ _____
Patient or Authorized Representative's Signature Date

Reason patient is unable or unwilling to sign: _____

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

Good Faith Estimate

Pricing for Physical Therapy with Ashley Friend, PT DPT

Prices are flat rates.

- First visit|$160| 60-minute session including evaluation and treatment
- Each Follow-up visit|$145| 60-minute treatment session
- Each Follow-up visit|$217.50| 90-minute treatment session
- Self-care group classes|$45| 60-minute
- Self-care 1:1 classes|$75| 60-minute
- Cancellation within 24 hours of your appointment time or no show to your appointment|$145|