AlignWell ATX, LLC

Stacey Gilmore, PT, RYT
512-627-9038

First Name Last Name

Name of Party Responsible for Payment (if different)

Address City State Zip Code

Cell phone # E-mail

Birthdate

Referring Physician Primary Care Referring Physician Phone #

Primary Care Physician Primary care Physician Phone #

Emergency Contact Name Emergency Contact Phone #

Patient Information Intake Information:

I have completed this information sheet and agree that the information that I have provided is accurate.
Signature_____ Date_____

Signature of guardian_____Date_____
(If under 18 years of age)

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Medical History

Name_____ Date_____

Please check “yes” or “no” to the following health problems.

Yes	No		Yes	No	
___	___	Cancer	___	___	Pulmonary/Breathing Problems
___	___	Diabetes	___	___	Liver disorder/disease
___	___	Heart Disease	___	___	Kidney/bladder disease
___	___	Chest Pain	___	___	Thyroid Disorder
___	___	High Blood Pressure	___	___	Intestinal Disorder
___	___	Blood clotting condition	___	___	Seizures
___	___	Unexplained weight loss	___.	___	Open sores/wounds
___	___	Bladder/bowel problems	___	___	Hepatitis
___	___	Steriod/blood thinner use	___.	___	HIV/AIDS
___	___	Allergies to latex	___.	___	Arthritis
___	___	Dizziness	___.	___	Rheumatism
___	___	Fainting	___	___	Severe Night pain
___	___	Smoking	___	___	Unexplained weakness
___	___	Recent or current illness	___	___	Other_____

___ ___ Are you pregnant or is there any chance you may be pregnant?

Please explain why you are currently in need of physical therapy/primary complaint?
_____

Please list surgeries/hospitalizations you have had (with date):_____
_____

Current or recent medications:_____

Recent imaging (x-rays, MRI, CT scan) or other tests:_____

I have completed this form accurately to the best of my knowledge. I understand that information left out, for confidentiality reasons, I may be putting myself or therapist at risk. I understand that if I choose to not disclose information in writing, I may verbally communicate conditions to my therapist.
Signature:_____ **Date**_____

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Medically Informed Consent for Treatment
I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services with Stacey Gilmore, PT, RYT. I understand that it is the therapist's sincere intent to educate me on every process, from completing the intake forms to what I may expect at the time of my discharge from physical therapy. Therefore, if "hands on" manual therapy techniques and/or exercises that are being used to restore normal function are not fully understood or desired it is my responsibility to obtain a clearer understanding or what the therapist's objectives are or immediately refuse this aspect of treatment. If I feel pain and/or do not consent or feel comfortable physically or emotionally with any aspect of the treatment, it is also my responsibility to make this immediately clear to the therapist providing treatment.

***** Payment is due at the time of service. Check, cash or Venmo only, please.**

***** Please read...Cancellation policy: Because I often have a waiting list, 24-hour notification is required for all cancellations so that attempts can be made to fill your vacated spot on my schedule. Patients with cancellations of less than 24-hour notification will be charged $50. No show appointments without prior notification will be charged the full amount of your visit.**

This consent shall be on-going for the treatment period.
I have read this form and fully understand and accept its terms and conditions:

Patient's name:_____

Patient's signature:_____ Date:_____

Signature of guardian (if patient is under 18 years of age):_____

Signature of witness:_____

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SUMMARY OF NOTIVE OF PRIVACY PRACTICES
Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will NOT use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written consent:
-To family members or close friends who are involved in your health care
-For purposes of public health and safety
-To government agencies for purposes of their audits, investigations, and other oversight activities
-To government authorities to prevent child abuse or domestic violence
-To the FDA to report product defects or incidents
-To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
-When required by court orders, search warrants, subpoenas, and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:
-To have access to and/or copy of your health information
-To receive an accounting of certain disclosures we have made of your health information
-To request restrictions as to how your health information is used or disclosed
-To request that we communicate with you in confidence
-To request that we amend your health information
-To receive notices of our privacy practices.

If you have questions, concerns or complaints regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.

Acknowledgement of Receipt of Notice from AlignWell, LLC.
I hereby acknowledge that I have reviewed the Summary of this medical practice's Notice of Privacy Practices and am aware that I may view a more detailed Notice of Privacy Practices.

Signature:_____ Date:_____
Printed name:_____

If not signed by the patient, please indicate relationship to patient:
__ parent or guardian of minor patient
__ guardian or conservator of an incomplete patient
__ beneficiary or personal representative of deceased patient