

AUTHORIZATION FOR TREATMENT AND RELEASE OF RECORDS

1. **Consent to Treatment/Testing:** I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.
2. **Release of Records:** I authorized the release of medical record information including but not limited to, information concerning drug related conditions, alcoholism, psychological documentation and psychiatric conditions, HIV testing, AIDS diagnosis, and AIDS related conditions, my medical conditions, to the applicable government authority, insurance carriers, third-party payers or their representatives, review organizations or their representatives, the physician or agency responsible for my follow-up care, and/or the healthcare facility that I am transferred to from Guenthner Physical Therapy.

I have read and understand the above:

Signature of Responsible Party _____ Date _____

Relationship to Patient _____ Witness _____

GUENTHNER PHYSICAL THERAPY ACKNOWLEDGMENT OF RECEIPT OF PROTECTION OF HEALTH INFORMATION PRACTICES

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by _____.

I, _____, authorize _____ to discuss my health information with the following persons:

- Spouse _____
- Children _____
- Parent _____
- Other _____

Date _____

Signature of Patient _____

Cancellation and No-show policy

The following are policies regarding cancellations and no-shows. We take this subject seriously at this clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatments. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full treatment for that week. In some cases this may not work.

We do reserve the right to charge \$35.00 for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.

You may need to be seen by a different therapist than the one that normally treats you if you rearrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before you are finally released. Either condition can seem like a reason not to come in; a) you're feeling worse and you feel treatment is not working, b) you're feeling better and it's a great day to go shopping or to sporting events. Neither of these conditions is legitimate as a reason not to come:

- a) If you are in pain, come in and get it fixed.
- b) If you are out of pain, now is the time that we can begin doing some real correction of underlying causes of your problem or educate you so you will not re-injure yourself.

When a patient doesn't show as scheduled, three people are hurt:

- 1) You, because you won't get the treatment you need as prescribed by the doctor or PT.
- 2) The therapist, who now has a space in their schedule since the time was reserved for you personally.
- 3) Another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will have you out of pain and back to full function as swiftly as possible. We're looking forward to working with you.

Patient
signature _____ Date _____

Sales Disclosure for GPT Patients

Guenther Physical Therapy's (GPT) primary business is providing outpatient rehabilitation services. As a convenience to our patients, GPT stocks commonly needed items that may be recommended for your rehabilitation by your doctor or therapist. All items are for sale on a cash, check, or credit basis only. You are free to purchase these items at any location. No insurance / Medicare will be billed for these items. These items may be covered by your insurance which may require you to buy from a different source and if so, your purchase from GPT may not be reimbursed. Medicare will not cover your purchase from GPT. You may submit the invoice to your insurance company directly.

Patient Signature: _____ Date: _____

*You will be reminded of this policy if you are ever in need of purchasing anything from GPT.

Guenther Physical Therapy Services Patient History Form

Name _____ Age _____ Date of Onset _____

Present Complaint: _____

How did it occur? (please check all that apply, describe)

Accident Fall Gradually Work Injury Lifting Sport Other: _____

Describe what caused the problem: _____

What medical attention have you received: _____

What tests have been done for this condition?

CT Scan MRI X-ray EMG Bone Scan None

At what facility were the tests done? _____

How would you rate your diet? Good Fair Poor

Do you have any of the following:

Unexplained weight gain or weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chewing or swallowing problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with speech, communicating, or memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems learning or lack of motivation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever experienced domestic violence or abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Past Medical History (please check/add/describe)

High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bone/joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Mental/Emotional	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma/breathing problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

Others: _____

Significant Past Surgeries: _____

Are you taking any prescription or over the counter medications? (please list) _____

Allergies to Medications: _____

Allergies to Latex/Tape? No Yes List: _____

1. Do you have pain? No Yes

If yes, mark your areas of **pain** with an "X" on the body chart.

My pain is: aching burning stabbing pins & needles
 dull sharp other: _____

Rank pain on a scale of 0-10. "0" being no pain and "10" being
"emergency room" level pain: 0 1 2 3 4 5 6 7 8 9 10

2. Do you have any areas of **numbness/tingling**: No Yes

If yes, mark numb areas with an ● on the body chart.

3. Is your pain worse in the (circle) morning / afternoon / evening?

4. Is the pain constant / or come and go? (circle)

5. What makes pain worse? _____

6. What eases pain? _____

7. Do you have difficulty sleeping? No Yes why? _____

What position do you sleep in? _____ How many pillows do you use? _____

8. Have you had physical therapy for this problem before? Yes No when? _____

9. Are you on an exercise program? Yes No Describe: _____

10. Do you have any exercise equipment available to you? Please list: _____

11. What was your normal level of activity prior to your injury? What did you like to do?
(recreation, leisure, hobby, sports) _____

12. Are you currently working? full light duty off homemaker not applicable

13. What is your occupation? _____

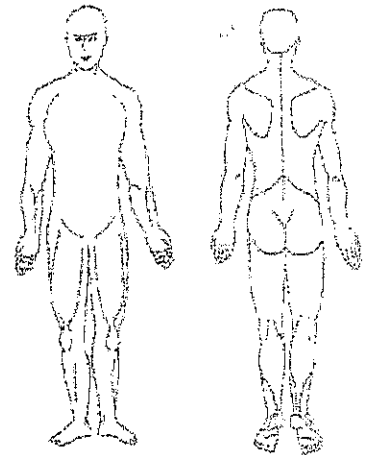
14. Who lives with you? _____

15. What does your job and/or home duties require? (check)

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> lifting | <input type="checkbox"/> pushing/pulling | <input type="checkbox"/> writing |
| <input type="checkbox"/> sitting | <input type="checkbox"/> reaching | <input type="checkbox"/> computer work/typing |
| <input type="checkbox"/> standing | <input type="checkbox"/> twisting | <input type="checkbox"/> repetitive movements |
| <input type="checkbox"/> walking | <input type="checkbox"/> kneeling/squatting | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> climbing | <input type="checkbox"/> carrying | <input type="checkbox"/> other: _____ |

16. List difficult work/homemaking duties: _____

17. When is your next doctor's appointment? _____



This is a list of your **goals** for physical therapy. Please check the goals you would like to work on. Add goals you have that are not listed, related to physical therapy/activities.

- Decrease pain.
- Improve my flexibility.
- Increase strength.
- Increase my endurance (increase time able to walk, exercise).
- Increase my mobility (getting in/out of bed, walking, going up and down stairs, get up/down from chairs/floor).
- Improve my activities of daily living (dress, house cleaning, laundry, etc.).
- Improve my posture.
- Return to work/improve my ability to work (increase sit/stand tolerance, increase ability to lift, carry, etc.)
- Return to sport.
- Improve my walking.
- Improve my balance and coordination.
- Other: _____

Patient Signature _____

Date _____

Guardian Signature (if patient is a minor) _____

Date _____

Reviewed by _____

Date _____