# Thin Air Physical Therapy

Patient's Name_____
DOB_____ Age_____Gender_____SSNumber_____

Marital Status _____ Email_____

Phone Number_____Secondary Phone_____
Address _____
City_____ State_____ Zip Code_____

Referred by_____

Primary Care Physician_____

Emergency Contact _____
Phone Number_____ Relationship_____

Guarantor Name_____
Guarantor DOB_____ Relationship_____
Guarantor Phone Number_____
Guarantor Address _____
City_____ State_____ Zip Code_____

Occupation/Employer _____
Employer Phone Number _____
Employer Address_____
City_____ State_____ Zip Code_____

Primary Insurance Carrier_____
ID#_____ Group ID #_____
Policy holder name_____ DOB_____

Secondary Insurance Carrier_____
ID#_____ Group ID #_____
Policy holder name_____ DOB_____

**Do you exercise regularly?** Yes No
**Do you use nicotine products?** Yes No
**Do you drink alcohol?** Yes No **If yes, how many drinks/day?**_____

**What is your primary complaint that brings you to physical therapy?**

_____

_____

**Please describe your primary symptom (i.e. sharp/stabbing/burning, mild/moderate/severe)** _____

_____

_____

**Have you received any other treatment for this condition?** _____

_____

**When did these symptoms start?** _____

**Please List Surgical History:**_____

_____

_____

_____

_____

**Do you have any of the following conditions?**

| | | |
|---|---|---|
| **Arthritis** | **AIDS/HIV** | **Cancer** |
| **Diabetes** | **Asthma** | **Heart Disease** |
| **Lung Disease** | **Epilepsy/seizures** | **Stroke** |
| **High/low blood pressure** | **Thyroid Disorder** | **Liver Disease** |
| **Depression** | **Anxiety** | **Blood clots** |

**Other:**_____

**Current Medications:**_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____Date _____
Patient Signature/Responsible Party Signature

## Consent to Photograph

I, _____, hereby (circle one) **AUTHORIZE/ DO NOT** Thin Air Physical Therapy to utilize photographic material of myself for social media/marketing purposes.

The photographic material may be kept on file for future social media/marketing purposes, and may be used in the future by Thin Air Physical Therapy for additional marketing reasons.

_____Date _____
Patient Signature/Responsible Party Signature

# Receipt of Notice of Privacy Practices Form

Effective April 14, 2003, I, _____, hereby acknowledge receipt of Thin Air Physical Therapy's Notice of Privacy Practices. Thin Air Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment, and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Thin Air Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Thin Air Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Thin Air Physical Therapy.

_____Date _____

Patient Signature/Responsible Party Signature

If you are not the patient, please specify your relationship to the patient

_____

_____

Print name

# INFORMED CONSENT FOR PHYSICAL THERAPY

I understand that I am a patient of Thin Air Physical Therapy and their independent physical therapy practitioners. My care is the exclusive responsibility of the practitioners of Thin Air Physical Therapy.

**Cooperation with treatment:** In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

**No warranty:** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

**Informed consent for treatment:** The term “informed consent” means that the potential risks, benefits and alternatives 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 and options available for my condition.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

**Potential benefits:** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

**Payment:** I understand that I am responsible for any charges not covered by insurance. I have read the above information and I consent to physical therapy evaluation and treatment.

_____

Patient Name

_____Date _____

Patient Signature/Responsible Party Signature