PERFORMANCE
Physical Therapy & Fitness
STRENGTH • MOBILITY • FUNCTION • LIFE

2286 Ritter Drive / Daniels WV 25832
Phone 304.237.5585 / Fax 681.207.7212

Informed Consent For Physical Therapy Services

Physical Therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, race, ethnicity, national origin or disability.

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitation procedures, mobilization, exercises and physical agents to aid in the patient achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Performance Physical Therapy does not guarantee what your reaction to a specific treatment will be, nor does it guarantee the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate in all physical therapy procedures and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties (physicians, radiologists, etc....)

Patient Name (PRINT) _____

Signature _____

Date _____

Patient Intake Form

Patient Information Verified DL: ☐ Yes ☐ No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: Email Address:

Date of Birth: _____ SSN#: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Employer Information

Employer Name: Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Address: City: State: Zip Code:

Work Phone Number: Patient Occupation:

Emergency Contact Information

Contact Name: Phone Number: Relationship to Patient:

Physician Information

Name of Referring Physician: _____ Telephone #: _____

Family Doctor: _____ Telephone #: _____

Additional Questions

Auto Related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
☐ Yes	☐ Yes	☐ Yes		
☐ No	☐ No	☐ No		

Additional Questions

Are you currently receiving Home Health Services? ☐ yes ☐ NO If yes name the agency _____

If Yes, what type of Home Health Services are you receiving? _____ last date of service: _____

Are you currently residing in a Skilled Nursing Facility? ☐ Yes ☐ No If yes, Name of Facility: _____

If Medicare, have you received PT, OT or Speech therapy services since the first of the year? ☐ Yes ☐ No

-If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No

Have you had any Physical, Occupational, Speech Or Chiropractic Therapy in the last year? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Insurance Information

Only complete the follow if the Primary or Secondary Policy is NOT the patient. Primary ☐ Secondary ☐

Last Name: First Name: Middle Initial: SSN: DOB:

Patient Relationship to Policy Holder: Gender ☐ Male ☐ Female

Employer Name: Employer Phone #

Primary Insurance Section	**Secondary Insurance Section**
Payer / Plan	Payer / Plan
Policy / ID#:	Policy / ID#:
Group #:	Group #:

I consent to Performance Physical Therapy, for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Performance Physical Therapy, to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:

☐ Workers Compensation ☐ Patient/Guardian ☐ Attorney ☐ Insurance Company

I certify that the information furnished by me is correct and here by direct and authorize payment of health care benefits due me by insurer of Performance Physical Therapy, understand that I am financially responsible for payment of fees regardless of insurance coverage.

I also certify that I have received the initial patient information from Performance Physical Therapy

I have read and understood Performance Physical Therapy privacy notice. I further understand that I may obtain a copy of this policy notice upon my request.

I have read and understand the billing and collection policies of Performance Physical Therapy, initial disclosure, cancellations and no show policies. I further understand that I may obtain a copy of the policy upon my request.

Client's Signature Date

Responsible Party's Signature (if patient is a minor)

Witness Signature Date