# YONI'S PHYSICAL THERAPY

First Name: _____ Middle Initial: _____ Last Name: _____

Gender: Male ☐ Female ☐ Date of Birth: _____ Marital Status: S ☐ M ☐ D ☐ W ☐

Address: _____ City: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

(Please circle one) Home Cell Work Home Cell Work

Email Address: _____

Emergency Contact: _____ Relationship: _____ PH#: _____

Referring Physician: _____

## INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____

ID #: _____ Group #: _____ Subscriber's DOB: _____

Secondary Insurance: _____ Subscriber's Name: _____

ID #: _____ Group #: _____ Subscriber's DOB: _____

Is this Work Related? **YES** ☐ **NO** ☐ Auto Related? **YES** ☐ **NO** ☐ (COMPLETE BELOW IF YES)

Name & Address of Employer: _____

Phone: _____ Fax: _____

Adjusters Name: _____ Phone: _____ Fax: _____

Name and Address of Insurance Co: _____

Claim # _____

**Do you have an Attorney? YES** ☐ **NO** ☐ Attorney Name: _____

Phone: _____ Ext: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(If patient is a minor)

# CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and subsequent treatment of my condition by a licensed physical therapist and his/her extenders employed at ***Yoni's Physical Therapy LLC.*** The physical therapist has fully explained to me the nature and purpose of the procedures, evaluation, and proposed treatment plan, and has witnessed my signature of this consent in his/her presence. The physical therapist has informed me of the expected benefits and most probable complications including discomfort associated with skilled physical therapy services. The physical therapist has also explained to me the risks of receiving no treatment.

The physical therapist has explained to me that there is no guarantee that the proposed plan of care will improve my condition and that the patient financial obligations (if any) are not contingent on outcome. They are contingent on services rendered. Attendance to appointments made for plan of care will be necessary for any progress of your condition. **NO CALL/NO SHOW** will greatly prohibit any benefit of care. There will be a **fee of $50.00** assessed to your account for **EVERY NO CALL/NO SHOW** to an appointment. I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I confirm and attest that I have read and fully understand the content of this form and I wish to proceed with physical therapy as outlined by the physical therapist.

Patient/Relative or Guardian _____/ _____
(Signature) (Printed Name)

Date _____ Relationship _____
(if signed by person other than patient)

Physical Therapist _____/ _____ Date: _____
(Signature) (Printed Name)

**ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATON**

I acknowledge that I received *Yoni's Physical Therapy Clinic's* notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____

Signature of Patient/Relative or Guardian: _____

Notes: This written acknowledgement must be completed no later than the first date of health care services or treatment provided to the patient after July 26, 2021. This acknowledgement must be retained in the patient's permanent records.

Patient Name:_____ Today's Date: _____

How did you hear about us? ☐ Physician's Office ☐ Friend/Neighbor ☐ Website/Facebook

☐ Other _____

1. Is this injury related to: ☐ Work ☐ Car Accident ☐ Other Potential Liability/Potential Lawsuit ☐ NA
2. Do you have a Primary Care Physician/Family Doctor? ☐ YES ☐ NO
   If yes, have you had an appointment with him/her in the last 1 month? ☐ YES ☐ NO
3. Race/Ethnicity:
   ☐ African American ☐ Native American ☐ Caucasian (White) ☐ Latino or Hispanic
   ☐ Other_____ ☐ Declined

**If you are a Medicare beneficiary, you are required by Medicare to answer question 4:**

4. Do you consume more than 7 alcoholic drinks in a week? ☐ YES ☐ NO
5. Please mark boxes below as appropriate:

| Please Mark One Box For Each Item | No | >1 year | <1 Year | Please Mark One Box For Each Item | No | >1 year | <1 year |
|---|---|---|---|---|---|---|---|
| Alzheimer's | ☐ | ☐ | ☐ | Muscular Dystrophy | ☐ | ☐ | ☐ |
| Cardiovascular Disease | ☐ | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | ☐ |
| Cerebral Vascular Accident (Stroke) | ☐ | ☐ | ☐ | Numbness/tingling | ☐ | ☐ | ☐ |
| Current Infection | ☐ | ☐ | ☐ | Obesity | ☐ | ☐ | ☐ |
| Degenerative Joint Disease | ☐ | ☐ | ☐ | Osteoarthritis | ☐ | ☐ | ☐ |
| Diabetes Mellitus Type 1 | ☐ | ☐ | ☐ | Osteoporosis | ☐ | ☐ | ☐ |
| Diabetes Mellitus Type 2 | ☐ | ☐ | ☐ | Pace Maker | ☐ | ☐ | ☐ |
| Dizziness/Faintness | ☐ | ☐ | ☐ | Parkinson's | ☐ | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | ☐ | Peripheral Neuropathy | ☐ | ☐ | ☐ |
| Fracture or Suspected Fracture | ☐ | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | Seizures | ☐ | ☐ | ☐ |
| History of Cancer | ☐ | ☐ | ☐ | Spinal Cord Injury | ☐ | ☐ | ☐ |
| Immunosuppression | | | | Skin Disease | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ | Traumatic Brain Injury | ☐ | ☐ | ☐ |
| Metal Implants | ☐ | ☐ | ☐ | Other..... (See Below) | ☐ | ☐ | ☐ |

Please specify if you have checked "Other" above: _____

_____

_____

Do you have Allergies? YES or NO Please specify _____

# MEDICATION LIST

Patient Name: _____ Today's Date: _____

**(Please check one box below)**

□ Not currently taking any medications

□ Currently taking medications, please list below:

| Drug Name | Dosage | Frequency (how many & how often) | Route of Administration (oral or injection) |
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## MEDICARE PATIENTS ONLY:

**Therapy Services:**

Have you had **ANY** therapy services elsewhere this year? Yes □ No □

If Yes, when? _____ **Have you been discharged?** Yes □ No □

**Home Health:**

Is anyone coming to your home to provide healthcare services? Yes □ No □

Nurse □ Home Health Aide □ Therapy Services □

If Yes, when? _____ **Have you been discharged?** Yes □ No □