Restore PT
relief • rehab • restore

2090 Pearl Street,
Boulder, CO 80302
Phone: (303)-284-3143

PATIENT INFORMATION

Name _____
Street Address _____
City _____ State _____ ZIP _____
Home/Cell Phone _____ Work Phone_____
Email _____
Date of Birth_____Age _____ Sex _____ Marital Status _____
Emergency Contact _____ Phone _____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Restore PT to furnish the medical care and treatment considered necessary and proper in assessing or treating _____'s physical and mental condition.

Patient/Guardian _____ Date: _____

Financial Policy Statement/Rates

Rates:
First Visit & Evaluation: $125 (60 -75 min. session)
Follow Up Visit: $115 (60 min. session)
Follow Up Visit: $75 (30 min. session)

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party signature Date

_____ _____
Restore PT Representative/Witness Date

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- The day-to-day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing or medical information with the person(s) named here:

Patient or Responsible Party Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

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Name (Printed): _____ Referring Source: _____

Date of Injury: _____

Please enter your: HEIGHT _____ WEIGHT _____ AGE _____

Are you currently taking any prescriptions or non-prescription medications? YES NO

List Medications

[ ] Anti-inflammatories _____

[ ] Muscle Relaxes _____

[ ] Pain Medications _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Emergency Room Care	___	___
General Practitioner	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	X-Rays	___	___

OTHER: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, bronchitis, or emphysema	___	___	Severe/frequent headaches	___	___
Shortness of breath/chest pain	___	___	Vision/hearing difficulties	___	___
Coronary heart disease or angina	___	___	Dizziness or Fainting	___	___
Heart attack or surgery	___	___	Weight loss/Energy Loss	___	___
Do you have a pacemaker?	___	___	Hernia	___	___
High blood pressure	___	___	Allergies	___	___
Stroke/ITA	___	___	Any joint/muscle pain	___	___
Blood clot/emboli	___	___	Joint Replacement	___	___
Epilepsy/seizures	___	___	Shoulder injury/surgery	___	___
Anemia	___	___	Elbow/hand injury/surgery	___	___
Infectious disease	___	___	Neck/back injury/surgery	___	___
Diabetes	___	___	Knee injury/surgery	___	___
Cancer or chemotherapy/radiation	___	___	Leg/ankle injury/surgery	___	___
Arthritis/swollen joints	___	___	Are you pregnant?	___	___
Osteoporosis	___	___	Do you smoke?	___	___
Sleeping problems/difficulties	___	___	Difficulty/Frequent urinating	___	___
Thyroid Condition	___	___	Night Pain	___	___

List any other information that would assist us in your care:

_____

Are you aware of your diagnosis? _____ YES NO

Patient or Responsible Party Signature: _____ Date: _____

I have reviewed this information with the patient.

THERAPIST (Printed) Kimberly A. Scales, PT THERAPIST (Signature) _____

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