# HEALING HANDS PHYSICAL THERAPY, P.L.L.C.
# NEW PATIENT INFORMATION SHEET

Date ______________

Name ____________________________________________________________________
Address __________________________________________________________________
City ____________________________ State __________ Zip Code _______________

Date of Birth _____________________ SS# ________________________________
Home Number ____________Cell Number ___________ Work Number ____________
Employer ___________________________Occupation ______________________________
Marital Status _____________________ Religious Preference ____________________
Emergency Contact Person ________________________________________________
Relationship _______________________ Contact Number_________________________

**Medical Information:**
List all Surgeries ___________________________________________________________
______________________________________________________________________________
List all current Medical Issues _____________________________________________
______________________________________________________________________________
List all your allergies (medicine/food/chemical)________________________________
______________________________________________________________________________
List all current Medications _______________________________________________
______________________________________________________________________________
Do you have a Pacemaker? Yes No
Are you currently or have you been treated for Cancer? Yes No
Have you had Physical Therapy this calendar year? Yes No
Have you seen a Chiropractor this calendar year? Yes No
If so, when and for how long? ______________________________________________
Were you injured on the job? Yes No Motor Vehicle Accident Yes No
Date of injury? ____________________________ Other ___________________________

Patient goals and expectations regarding therapy outcomes:
1. ___________________________________________________________________________
2. ___________________________________________________________________________
3. ___________________________________________________________________________

Whom may I thank for referring you?
______________________________________________________________________________

# HEALING HANDS PHYSICAL THERAPY, P.L.L.C.
# CONSENT FOR TREATMENT

**CONSENT FOR TREATMENT:** I have a condition for which I require physical therapy. I request and consent to receiving therapy services necessary for my condition to include, but not limited to, therapeutic exercise, manual therapy, and modalities.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I authorize HEALING HANDS PHYSICAL THERAPY, P.L.L.C. to use, disclose, and provide copies of information in my medical records to carry out treatment, payment, or other purposes related to my care. This means that the employees of HEALING HANDS PHYSICAL THERAPY, P.L.L.C. may use my medical information in order to treat me or provide any services to me related to my condition. I authorize HEALING HANDS PHYSICAL THERAPY, P.L.L.C. to provide a copy of my medical information to my health plan, health insurance company, Medicare, Medicaid, or other payers for payment purposes. **I AM AUTHORIZING INFORMATION TO BE RELEASED THAT MAY INCLUDE INFORMATION ABOUT COMMUNICABLE DISEASES OR VENEREAL DISEASES WHICH MAY INCLUDE DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS(HIV) ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR "AIDS."**

**ADVANCE DIRECTIVES AND PATIENT RIGHTS FOR OUTPATIENTS:** By signing this consent to treat, you acknowledge the right to share your decision to create and or provide a copy of your advance directives with HEALING HANDS PHYSICAL THERAPY, P.L.L.C.

***I acknowledge receiving a copy of HEALING HANDS PHYSICAL THERAPY, P.L.L.C.'s Conditions of Admissions.***

____________________________ __________ ____________________________

Printed Patient's Name | Date | Patient's Signature Or Representative

# HEALING HANDS PHYSICAL THERAPY, P.L.L.C.
## INSURANCE AUTHORIZATION

I hereby authorize HEALING HANDS PHYSICAL THERAPY, P.L.L.C. to furnish information to insurance carriers concerning my treatments, and I hereby assign to HEALING HANDS PHYSICAL THERAPY, P.L.L.C. all payments for physical services rendered to myself or my dependents. I understand that I am responsible for the full amount at the end of each therapy session.

Print Patient's Name ______________________________

Patient's Signature ________________________________

Print Insured's Name ______________________________

Insured's Signature ________________________________

Date __________________

# ACKNOWLEDGEMENT OF RECEIPT OF: NOTICE OF PRIVACY PRACTICES

HEALING HANDS PHYSICAL THERAPY, P.L.L.C.

I hereby acknowledge that I received a copy of this medical practice's *NOTICE OF PRIVACY PRACTICES.* I further acknowledge that I will be offered a copy of any amended *NOTICE OF PRIVACY PRACTICES* at each appointment.

**Signed:** ________________________________________ **Date:** __________________

**Printed Name:** __________________________________ **Telephone:** _____________

**Requested Restrictions:** _____________________________________________________

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If not signed by the patient, please indicate:

**Relationship:**

_____ Parent or Guardian of minor patient

_____ Guardian or conservator of an incompetent patient or agent under power-of-attorney.

_____ Beneficiary or personal representative of deceased patient

**Name of patient:** __________________________________________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

***FOR OFFICE USE ONLY:***

Signed form received by: _____________________________________ Date:___________

Restriction: Agreed ___________ Disagreed ___________

If disagreed with restrictions, reason: ____________________________________________

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**Acknowledgement refused:**

Efforts to obtain: ____________________________________________________________

By: ____________________________________________________________

Patient's reason for refusal: ___________________________________________________

_____________________________________________________________________________

Dear Client,

Thank you for your interest in receiving manual therapy treatment at Healing Hands Physical Therapy. I take your medical care very seriously, and my hope for you is that you might experience healing beyond your expectations.

**CLIENT INTAKE**: Enclosed is a packet of information for you to print and complete prior to your first visit. This information is important and must be completed prior to treatment administration. Please fill out the “New Patient Information Sheet” and sign the “Consent for Treatment,” the “Insurance Authorization,” and the “Acknowledgment of Receipt of: Notice of Privacy Practices” where indicated. If you do not plan to bill your insurance company for reimbursement, you may decline signature on the “Insurance Authorization” form. If you have any questions or are unsure how to appropriately answer any given question, please leave it blank and we will go over it together at your first appointment. If you wish, you may also want to provide a list detailing your medications or past medical history instead of writing out this information on the “New Patient Information Sheet.”

**PAYMENT**: As stated in the packet, payment is due in full upon completion of each treatment session. Cash or check is an acceptable form of payment; however, returned checks for insufficient funds will incur a fee of $30.00 due upon notice. I apologize for any inconvenience caused by my inability to accept credit card payments.

Patient Acknowledgment:_____________________

**CANCELLATION COURTESY**: Notice of cancelling your appointment must be given 24 hours prior to the originally scheduled treatment. If sufficient notice is not provided, you will be responsible for payment in full of such treatment session.

Patient Acknowledgment:_____________________

**THANK YOU** again for allowing me to be a part of your medical team. I look forward to meeting you and developing a plan together to achieve your health related goals.

Audra R. Thompson, PT

# HISTORY OF PRESENT ILLNESS

1. Describe in **detail** how you came to have your current complaint(s):________
2. What date did your complaint(s) occur?________________________________
3. Where is/are your complaint(s) located?________________________________
4. Is your complaint CONSTANT or does it COME AND GO? (please circle)
5. Describe your complaint(s). (What does it feel like?):____________________
6. Do you have numbness or tingling in your arms or legs? YES NO
   Explain:____________________________________________________
7. What makes your complaint(s) worse?__________________________________
8. What makes your complaint(s) better?_________________________________
9. On a scale from 0-10 what would you rate your current complaint/pain (0=no pain, 10=emergency room pain)

   Complaint #1:______________________ Complaint #2:____________________
   Now:____________ Now:________________
   At its worst:______ (in last 2 wks) At its worst:__________ (last 2 wks)
   At its best:_______(in last 2 wks) At its best:___________(last 2 wks)