In Balance Physical Therapy

Patient history

Name: _____ Date: _____

Reason for Physical therapy _____

_____

_____

Where do you have pain? _____

Is there anything that makes it better or worse? _____

_____

When did the injury start? Was there something that triggered it? _____

_____

_____

Have you had any treatment for this? IF yes – What was done? _____

_____

_____

Are you on any medications for this injury? _____

Does the pain travel to any other areas of the body? _____

_____

_____

What things are you unable to do, have problems performing, or that you avoid doing because of your injury?

_____

_____

_____

Are there any activities you are now performing with pain that you previously were able to perform pain free?

_____

_____

What would happen if this condition got worse? _____

_____

In Balance Physical Therapy

Registered Physical Therapist

CLIENT HISTORY MEDICAL PROFILE

Date: _____ EMAIL: _____

Patient Name: _____ Phone: _____

Marital Status: _____ Sex: _____ D.O.B.: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____

Emergency Contact: _____ Phone: _____

Referral Source: (be specific) _____

Referring Physician: (if any) Last Name: _____ First Name: _____

General MD: Last Name: _____ First Name: _____

Please list any prescription or non-prescription medications you are currently taking:
Please be specific: _____

_____

Please check any condition you may have/had:

- ☐ Leg/Ankle/Foot
- ☐ Back
- ☐ Elbow/Hand
- ☐ Shoulder
- ☐ Neck
- ☐ Knee
- ☐ Joint/Joint
- ☐ Pins/Metal Implants
- ☐ Asthma/Bronchitis
- ☐ Shortness of Breath/Chest Pain
- ☐ Coronary Heart Disease/Angina
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Blood Clot/Emboli
- ☐ Headaches
- ☐ Hernia
- ☐ Epilepsy
- ☐ Thyroid
- ☐ Anemia
- ☐ Diabetes
- ☐ Cance/Chemotherapy/Radiation
- ☐ Arthritis/Swollen Joints
- ☐ Osteoporosis
- ☐ Sleeping Problems
- ☐ Bowel/Bladder Problems
- ☐ Vision/Hearing
- ☐ Numbness/Tingling
- ☐ Dizziness/Fainting
- ☐ Weakness
- ☐ Unusual Weight Gain/Loss
- _____ Do you Smoke?

Please Specify: _____

_____

Signature Date

In Balance Physical Therapy

Registered Physical Therapist

AUTHORIZATION AND CONSENT TO TREAT

I hereby authorize In Balance Physical Therapy Inc. to provide treatment, supplies, and equipment. I have been informed of services and purpose of treatment, common side effects, alternative treatment modalities, and approximate length of treatment. Consent may be revoked in writing prior to or during the treatment period.

I give In Balance Physical Therapy Inc, authorization to contact me via telephone and/or mail up to one year following my discharge to determine if the therapy I received has had a positive effect.

In the event of a life threatening emergency occurs on the premised of the clinic or home in which emergency care or treatment is needed, I authorize In Balance Physical Therapy Inc. to arrange for care necessary for my emergency condition. I further authorize the medical facility or personnel to provide emergency medical treatment. I agree to be responsible for medical and related costs as a result of such emergency treatment.

MY SIGNATURE BELOW INDICATED THAT I ACKNOWLEDGE AND ACCEPT THE ABOVE AUTHORIZATION AND CONSENT TO TREATMENT:

Signature Date

6030 Bird Road • Miami, FL 33155
Located: Inside Accurso Chiropractic building
P: 305-667-1188 • InBalancePhysicalTherapy.net

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Registered Physical Therapist

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you **do not forget.**

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk. The make-up appointment needs to be in the same week preferably the very next day.

In an instant of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **$39.00** fee.

In instances of repeated non-compliance with your schedule visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Cathy Parbst-Accurso, PT

I have read and understand this policy: _____ Date: _____

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ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

For services rendered by In Balance Physical Therapy Inc, I hereby assign the benefits due me by my insurance company to In Balance Physical Therapy Inc. I agree that if these benefits are insufficient to cover my entire cost of my treatment and if the illness/disability is not covered by my insurance policy, I will be responsible for the entire bill and/or that part not covered by my insurance.

If I am a private pay patient, I understand that there is NO assignment of benefits and this agreement becomes solely one of financial responsibility. I thereby agree to pay in full the cost of treatment rendered by In Balance Physical Therapy.

I give In Balance Physical Therapy Inc, authorization to release information to my insurance company and give its representatives and/or my doctors for the purpose of processing my claim. I also give Physical Therapy Inc, further permission to contact my employer, should the need arise, to obtain any information relative to my insurance benefit. I understand that this authorization is valid for seven (7) years from date of discharge by Physical Therapy Inc, or prior to that upon request.

MY SIGNATURE BELOW INDICATED THAT I ACKNOWLEDGE AND ACCEPT THE ABOVE ASSIGNEMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY POLICIES.

Signature Date

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ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE HIPPA

In Balance Physical Therapy is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have read the Notice of Privacy Practices for:
In Balance Physical Therapy.

Name of Patient (PRINT): _____

_____

Signature of Patient or legal guardian Date

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Waiver and Release

Name: _____ Phone #: _____

Street: _____ City/State: _____ Zip: _____

Email: _____

Check the boxes below that pertain to you.

- ☐ Acute inflammations and infections
- ☐ Active Cancer
- ☐ Acute joint disorders and Arthrosis
- ☐ Heavy migraine
- ☐ Acute Rheumatoid Arthritis
- ☐ Serious cardiovascular diseases, such as heart and vascular
- ☐ Fresh surgery wounds
- ☐ Heart disorders
- ☐ Recently placed metal or synthetic implants such as pacemaker, intra-uterine device, and cochlear implants
- ☐ Recent joint implants, such as foot, knee and hip implants
- ☐ Pregnancy
- ☐ Gallstones
- ☐ Epilepsy
- ☐ Recent Thrombosis or possible Thrombotic complaints
- ☐ Tumors
- ☐ Severe Diabetes
- ☐ Kidney Stones
- ☐ Low back complaints such as acute Hernia, Discopathy and Spondylolysis

Agreement and Release of Liability

1) I acknowledge that I am aware that the above medical conditions are possible contraindications to using the Vibration Machine.

2) In consideration of being allowed to use the T-Zone Vibration Machine, I do hereby waive, release and forever discharge T-Zone Vibration Technology, its officers, affiliates, agents, employees and representatives from any and all responsibilities or liabilities from injuries, illness or damages.

_____

Signature Date