RANGE PHYSICAL THERAPY MEDICAL HISTORY FORM

Name____ Daytime Phone #________________________

Occupation:____

Emergency Contact (name and phone number)____

• Name of primary physician____

• Name of referring physician____

• When are you scheduled to return to your referring physician?__________________________________

• Have you seen anyone else for your current condition?

□ Physician/MD □ Chiropractor □ Podiatrist □ Orthopedic Surgeon □ Dentist □ Neurologist

□ Physical Therapist □ Other (specify: _______________)

Past Medical History:

Have you ever had any of the following conditions? Check all that apply.

□ High blood pressure □ Heart condition □ Stroke □ Osteoporosis □ Peripheral Neuropathy □ Seizures/Epilepsy

□ Vision problems □ Diabetes □ Hearing problems □ Fainting/dizziness □ Emphysema □ Frequent or severe headaches

□ Bowel/bladder problems □ Cancer □ Arthritis □ Asthma □ Other:______________________________

Have you had any falls in the past year? YES NO If so, about how many? ________________

Do you have a history of fractures? YES NO Where?_______________________________

Do you have any metal implants? YES NO Where?_______________________________

Do you smoke? YES NO How much per day?____________________

Do you exercise regularly? YES NO How often?____________________________

Do you have any known allergies? YES NO Please list_____________________________

Are you pregnant or think that you might be? YES NO

Medications: Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking

____

____

Surgeries: Please list all surgeries including dates:____

____

Diagnostic Tests: Please check any tests or procedures that have been done for your current condition.

□ X-rays □ MRI □ CT scan □ Bone scan □ EMG □ Blood work □ Bone density □ Ultrasound

Current Condition

• What is the problem you are here for?____

• What is the date when the problem started? ____

• Have you had similar symptoms before?____

• Have you had previous treatment for this condition?____

Patient Signature____ Date________________________

Therapist Signature____ Date________________________

Range Physical Therapy Consent Form

Patient's Name:______________________

_____ **Consent:** I consent to and authorize Range Physical Therapy LLC to administer physical therapy treatment. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

_____ **Minor Patients:** The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.

_____ **Release of Information:** Range Physical Therapy LLC releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

_____ **No Guarantees:** I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

_____ **Collections:** If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by Range Physical Therapy LLC to collect said fees from the Responsible Party.

_____ **Returned Checks/Liens:** Returned checks are subject to a $25.00 administrative charge as well as the bank's charge for bounced checks. In addition, the account will incur a 1.5% interest charge for balances >30 days.

_____ **No Show/Cancel/Late Policy:** If you are not present for the start time of your visit, your therapist may not have the full allotted time to treat you and you may be subject to a shortened session. Not showing up to a scheduled appointment will Result in a $50 fee.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Patient/Responsible Party Signature: ________________________ Date: _______________

Signature authorizing treatment a Minor: ______________________ Date: _______________

Authorization for release of Private Health Information (PHI)
I authorize the release of PHI for medical purposes to:
___________________ / Relationship _______________

___________________ / Relationship _______________

Patient / Responsible Party Signature: __________________________ Date: ______________