PHYSICAL THERAPY OF TULSA

First Name _____ Last Name _____ Date of Birth ____/____/____ Social Security ____-____-____

Home Address _____ City _____ State _____ Zip _____

Email _____ * *Please print legibly*

Would you like an invitation to online bill pay? ☐ Yes ☐ No

(____) Home Phone _____ (____) Cell Phone _____ Gender _____ Marital status _____

*How would you like to be reminded about your appointments? ☐ E-Mail ☐ Text Message ☐ Voice call (Home/ Cell)
Please circle

Emergency Contact _____ (____) Phone _____ Relationship _____

Who can we thank for referring you to the clinic? _____

Policy Holder **(*) indicates required information if you are not the policy holder.**
IF YOU ARE THE POLICY HOLDER PLEASE CHECK THE BOX ☐ SELF

*First Name _____ *Last Name _____ *Date of Birth ____/____/____ * Relation Spouse / Parent *Please circle one*

Insured Address _____ City _____ State _____ Zip _____

Insured SS# ____-____-____ (____) Insured Phone number _____ Do you have **secondary / tertiary** coverage? ☐ Yes ☐ No

Is this: ☐ Work related ☐ Vehicle accident ☐ Other accident If yes, please specify: _____

What are we treating you for today? _____ ☐ Right ☐ Left

Date of Injury or surgery _____ Type of injury or surgery _____ Referring Physician _____

*Are you receiving or have you received home health, chiropractic care, or other physical therapy this year? ☐ Yes ☐ No

I certify that all of the information provided here is true and correct and may be used to submit information to my insurance company. I understand I am responsible for any charges that may occur due to incorrect information given here.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Physical Therapy Consent

Informed Consent and Waiver & Release of Liability

In agreeing to receive care provided by Physical Therapy of Tulsa, LLC ("Physical Therapy of Tulsa"), located at 6767 S Yale Ave. Suite B Tulsa OK 74136, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Physical Therapy of Tulsa and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Physical Therapy of Tulsa, or by any other person; (d) I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time; (e) I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Physical Therapy of Tulsa and its representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Physical Therapy of Tulsa.

I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

Consent: I consent to and authorize Physical Therapy of Tulsa (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. 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.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT PHYSICAL THERAPY OF TULSA FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH BY ANY CAUSE.

_____	_____	_____
Patient/Guardian Signature	**Witness Signature**	**Date**

DISCLOSURE OF HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree Physical Therapy of Tulsa and its duly authorized employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, any other individuals that I may indicate below who may contact *Physical Therapy of Tulsa* on my behalf.

List the name of individual(s), relationship and to identify the type of information to be disclosed

PLEASE PRINT

☐**Medical** ☐ **Billing** _____ _____
Name Relation

☐**Medical** ☐ **Billing** _____ _____
Name Relation

I understand:

- At any time, I may add or remove individuals from this list by notifying Physical Therapy of Tulsa my desire to do so. I understand that until I notify Physical Therapy of Tulsa of requested changes to this list, Physical Therapy of Tulsa may rely on this list and disclose information the individuals listed above.
- Information disclosed to the individuals identified above may be subject to disclosure by the recipient and no longer protected by federal law.

* I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as, hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (AIDS). My medical information may indicate that I have or have been treated for psychological or psychiatric condition or substance abuse.

_____ _____ _____
Patient/Guardian Signature **Witness Signature** **Date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

CONSENT TO TREATMENT: I consent to services at Physical Therapy of Tulsa. In so doing, I understand acknowledge and affirm that such services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____ **Initials**

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____ **Initials**

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Physical Therapy of Tulsa and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____ **Initials**

NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have reviewed a copy of Physical Therapy of Tulsa's notice of privacy practices and agree to their use and disclosure of my protected health information for treatment payment and healthcare operations _____ **Initials**

_____ _____ _____
Patient/Guardian Signature **Witness Signature** **Date**

PHYSICAL THERAPY OF TULSA

PATIENT AUTHORIZATION FOR TREATMENT AND FINANCIAL STATEMENT

Authorization for Treatment: By virtue of my signature, I authorize Physical Therapy of Tulsa (PTOT) and any of its employees or other authorized personnel or agents, to provide general healthcare services to me.

Financial Statement: Payment is due immediately upon the provision of services unless a previous arrangement has been made. All patients are required to pay total charges, the full amount of their copayment, or a minimum of $50.00 at the time of appointment if PTOT files the claim for benefits with the primary insurance company.

I understand that if I am unwilling to authorize PTOT to obtain reimbursement or determine coverage, PTOT may require me to pay in full on a cash basis at the time services are rendered. I accept that I am bound by PTOT's payment policies, as articulated above.

Any patient having outstanding balance on their account which is unpaid for **60 days** or more will be required to pay for any charges incurred at the time of service and to make arrangements for the payment of any outstanding balance due on the account.

Any patient having an outstanding balance on their account that is unpaid for **90 days** or more will have their account turned over for collection and any future services will be made available only on an immediate cash basis. PTOT may, at its discretion, choose to work with those patients who incur accounts having a large dollar balance, by creating a payment schedule or other appropriate arrangement. In the event of my default I agree to pay all costs of collection incurred by PTOT, including but not limited to my attorney fees.

PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible we ask that you agree to this policy and make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require a **24 hour notice.** Please call us as soon as you know you cannot make your scheduled appointment so that another patient may be given your appointment time. We can be reached by phone at 918-494-3000.

"No shows" or last minute cancellations leave empty appointment times that could be filled by other patients waiting to receive medical care. For that reason, patients that do not honor their appointments will be charged a cancellation or No Show fee: **$50**

If you "no show" your scheduled appointment without contacting us by the following business day to confirm your subsequent appointment we will remove all existing appointments until we are contacted. If you cancel 3 consecutive appointments, your remaining scheduled appointments will be removed from the schedule until you discuss your plan of care with your therapist or referring physician.

Less than a 24 hour notice or a NO SHOW will result in a fee of: $50.00

We realize that on a rare occasion, emergencies may arise and we will address these situations with you at that time. We thank you for working with us to ensure services are provided to you and others, in the best way possible.

Signature: : By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, I agree to be bound by all of PTOT's payment policies and that I have been given adequate opportunity to ask questions about the same.

_____	_____	_____
Patient/Guardian Signature	**Witness Signature**	**Date**

PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Work status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disability ☐ Retired

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you use tobacco? ☐ Yes ☐ No **If "Yes," how much?** _____

Are you pregnant or is there a possibility that you could be pregnant? ☐ Yes ☐ No

Past Medical History (Check all that apply): ☐ Check if you've attached a separate sheet

☐ MRSA
☐ Diabetes
☐ Hypertension
☐ Mitral Valve Prolapse
☐ Heart Attack
☐ Congestive Heart Failure
☐ DVT/Clots
☐ Irregular Heartbeat
☐ Pacemaker
☐ Internal Defibrillator
☐ Emphysema
☐ Asthma
☐ COPD
☐ Chronic Bronchitis
☐ Tuberculosis
☐ Frequent Heartburn
☐ Gastric Reflux
☐ Hiatal Hernia
☐ Cirrhosis
☐ Hepatitis
☐ Gallbladder Disease
☐ Stomach Ulcer
☐ Thyroid Disease
☐ Kidney Infection
☐ Kidney Stone(s)
☐ Kidney Dialysis
☐ Anemia
☐ Bruising
☐ HIV/AIDS
☐ Stroke/TIA
☐ Epilepsy/Seizures
☐ Alzheimer's
☐ Parkinson's Disease
☐ Headaches
☐ Restless Leg Syndrome
☐ Fibromyalgia
☐ Spinal Cord Injury
☐ Artificial Joint
☐ Arthritis
☐ Depression
☐ Anxiety
☐ Mental Illness
☐ Metal Implants
☐ Osteoporosis
☐ Osteopenia
☐ Vitamin Deficiency
☐ Other
_____

What surgeries have you had (Check all that apply)? ☐ Check if you've attached a separate sheet

☐ Cataract
☐ Gallbladder
☐ Prostate
☐ Carpal Tunnel
☐ Tonsillectomy
☐ Hernia
☐ Joint
☐ Heart Bypass
☐ Open Heart
☐ Skin Graft
☐ Back
☐ Neck
☐ Bladder
☐ D & C
☐ Splenectomy
☐ Appendectomy
☐ Hysterectomy
☐ Breast Surgery
☐ Tubal Ligation
☐ C-Section
☐ Colon/Bowel/Intestine
☐ Kidney
☐ Thyroidectomy
☐ Fracture Repair and Location(s) _____
_____
☐ Other: _____
_____
_____
_____

Reviewed:_____

Name: _____ **Date of Birth:** _____

Do you have or have you had cancer: ☐ Yes ☐ No **What type of cancer?** _____

How is it being treated? _____

_____

Allergies (list all): _____

_____

Current Medications: ☐ Check if you've attached a separate sheet

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you had physical therapy this calendar year? ☐ Yes ☐ No **Occupational therapy?** ☐ Yes ☐ No

If "Yes," where? _____

What issues are you seeking help for from physical therapy? _____

_____

Who else have you seen for this issue (check all that apply)? ☐No one ☐Medical Doctor ☐Chiropractor

☐ Physical Therapist ☐ Occupational Therapist ☐ Massage Therapist ☐ Physiatrist ☐ Athletic Trainer

☐ Speech Therapist ☐ Nutritionist ☐ Other: _____

What tests have you had? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ PET Scan ☐ Ultrasound ☐ Angiogram

☐ Venous Doppler ☐ Other _____

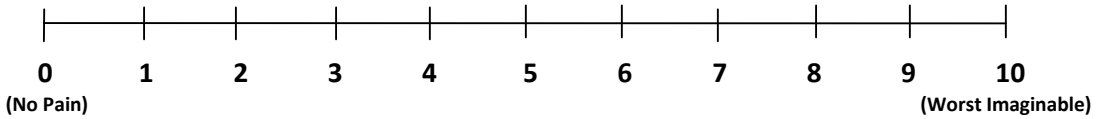
Reviewed:_____

PHYSICAL THERAPY OF TULSA

Name: _____ **Date of Birth:** _____

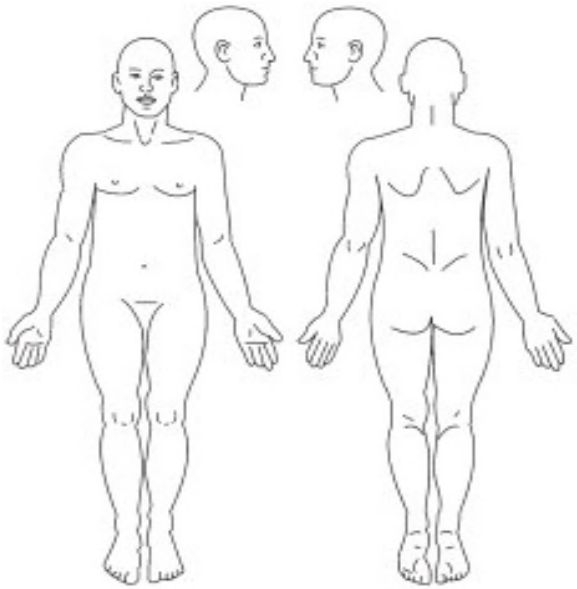
Please rate your pain today (if applicable):

Please rate your pain at its best (lowest) and at its worst (highest) (if applicable):



Please indicate the location of your symptoms on the diagram. Use the key below to indicate the kind of symptoms you are having.

Sharp: ^^^^
Shooting: ↓↓↓↓
Dull Ache: **OOOO**
Burning: **XXXX**
Numbness/Tingling: **////**
Other: **++++**



FOR OFFICE USE ONLY:

Obj *: _____
_____
_____
_____

Subj *: _____
_____
_____
_____

Please tell us what things you would like to return to doing that you are having difficulty doing now.

_____

_____

Reviewed:_____

Name:_____ Date: _____ Date of Birth: _____

At Physical Therapy of Tulsa we appreciate your time and we know you have a lot of paperwork to fill out. We use this information to help us give you the best and most complete care possible. Thank you for answering the following questions to the best of your ability.

Have you recently experienced any of the following:

Abnormal sensations (e.g. numbness, pins and needles)?	Yes	No
Headaches?	Yes	No
Night pain?	Yes	No
Sustained morning stiffness?	Yes	No
Light-headedness?	Yes	No
Trauma (e.g. car accident, fall)?	Yes	No
Night sweats?	Yes	No
Changes in bowel/ bladder (e.g. constipation, frequency, incontinence)?	Yes	No
Easy bruising?	Yes	No
Changes in vision?	Yes	No
Changes in menstruation patterns?	Yes	No
Gait or balance disturbances?	Yes	No
Chest pain with rest?	Yes	No
Shortness of breath?	Yes	No
Muscle weakness?	Yes	No
Failure of conservative intervention (failure to improve within 30 days)?	Yes	No
Excessive sweating?	Yes	No
Edema (swelling) or weight gain?	Yes	No
A heartbeat in your abdomen when you lie down?	Yes	No
Cramps in your legs when you walk for several blocks?	Yes	No
Abdominal pain?	Yes	No
Changes in the integrity of your nails?	Yes	No
Prolonged use of corticosteroids?	Yes	No
Feeling down, depressed, or hopeless?	Yes	No
Being bothered by little interest or pleasure in doing things?	Yes	No

Reviewed _____