

Client Info

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Employer / School _____ Occupation / Sport _____

How did you hear about The Wellness Bank? _____

Referring Physician _____

Area(s) to be treated _____

Date of Injury / Onset of Pain _____ Date of Surgery _____

Emergency Contact

Name _____

Phone _____ Relationship _____

Parent or Guardian (if under 18)

Name _____ Relationship _____

Address _____

Phone _____

Please initial and sign at the bottom

_____ (initial) **Privacy Policy:** I have read the Health Information Privacy Policy attached.

_____ (initial) **48 Hour Cancellation Policy:** Your appointments are one-on-one with your practitioner, therefore please provide at least 48 hours notice to reschedule or cancel. Your appointment time is reserved exclusively for you. Late cancellations will be charged to the card on file \$100.

_____ (initial) **Texting Consent:** I agree to receive text messages from The Wellness Bank for appointment reminders. Message & data rates may apply and message frequency varies.

_____ (initial) **Billing:** All payments, including insurance co-pay and deductible, will be collected at the time of service. Your co-pay is often an estimation of your cost, based on the benefits quoted by your insurance company. The Wellness Bank will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nonetheless, it is ultimately your responsibility, its benefits and the obligations are placed on you. It is not the responsibility of The Wellness Bank to verify your insurance coverage or determine which services are or are not covered. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

_____ (initial) **Insurance Payments:** Some insurance companies reimburse the patient directly instead of the provider. You may receive insurance reimbursement checks from your visits directly. It is your responsibility to cash or deposit these checks in a timely manner and submit the same amount (via cash, check or credit card) to The Wellness Bank within 7 days of receiving the insurance reimbursement.

_____ (initial) **Balances Due:** As a courtesy, we will verify your insurance coverage for physical therapy services in our office. While we make every effort to accurately estimate your financial obligation (copay/deductible), insurance companies will not guarantee benefits/payment amounts for non-participating providers, and therefore a balance due may remain, once insurance processes your claim. We will send a billing statement to both the mailing and email addresses you provide in your new patient paperwork. Should you neglect to pay the amount due within 30 days, a 1% monthly interest/finance charge will be applied to your outstanding balance and will reflect on the subsequent billing statement (12% APR).

_____ (initial) **Direct Access:** (Only for Physical Therapy patients without a prescription): You may receive direct physical therapy treatment services for 12 visits or 45 days (whichever comes first), after which a physician's signature is required on the Physical Therapist's plan of care or a written prescription.

_____ (initial) **Prescriptions:** It is your responsibility to keep your prescription up to date or request an updated one from your referring doctor every 90 days.

Signature _____ Date _____

General Health Questionnaire

Do you currently experience any of these symptoms? (Circle yes or no)

Fevers / chills / sweats	Yes	No
Unexplained weight loss / gain	Yes	No
Malaise (feeling generally unwell)	Yes	No
Unusual fatigue	Yes	No
Nausea / vomiting	Yes	No
Headaches	Yes	No
Dizziness / lightheadedness / loss of consciousness	Yes	No
Blurred vision	Yes	No
Numbness / tingling	Yes	No
Weakness	Yes	No
Muscle cramping	Yes	No
Chest pain / palpitations	Yes	No
Swelling in feet or hands	Yes	No
Difficulty breathing / shortness of breath	Yes	No
Difficulty breathing when lying down	Yes	No
Cough / change in cough / blood in phlegm	Yes	No
Wheezing	Yes	No
Difficulty swallowing	Yes	No
Heartburn / indigestion	Yes	No
Change in appetite	Yes	No
Specific food intolerance	Yes	No
Bowel pattern changes (color, texture, frequency)	Yes	No
Difficulty urinating (starting, stopping)	Yes	No
Urine frequency changes	Yes	No
Possibility of pregnancy	Yes	No

Other medical conditions or prior surgeries _____

Current Medications: _____

Family medical history (birth parents/siblings): _____

Consent to Treatment

Physical therapy is a patient care service provided in response to a wide range of medical care needs of patients of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization / manipulation, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

We would appreciate your full cooperation with the evaluation and treatment program. Because of the nature of services provided, you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times. Should you feel uncomfortable or embarrassed, you may refuse or stop the procedure.

There are certain inherent risks with treatments because you will be asked to exert effort and perform activities with increasing degree of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. We will take every precaution necessary to ensure you are protected from any potentially hazardous situation. You will never be forced to perform any procedure you do not wish to perform.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures and to comply with the plan of care as it is established. I have read this consent form and authorize the release of medical information to appropriate third parties.

Signature _____ Date _____

Credit Card Authorization

Circle one: VISA - MASTERCARD - AMEX - DISCOVER

Credit Card# _____

Expiration: _____

3 Digits on back / 4 on Front(amex): _____

Billing Address: _____

48 Hours Cancellation Policy: Your appointments are one-on-one with your practitioner, therefore please provide at least 48 hours notice to reschedule or cancel. Your appointment time is reserved exclusively for you. Late cancellations will be charged to this card on file the full session amount of \$100.

Signature _____

Date _____