Welcome to Restore Your Core Physical Therapy!

Please print the forms and fill them out *prior to your initial appointment.* You are welcome to email the completed forms to Restore Your Core Physical Therapy (amy@restoreyourcorept.com) or you can bring them to your first appointment. If you prefer to fill the forms out in the office, please inform the therapist 24 hours in advance (email or call) and plan to arrive 30 minutes early to allow adequate time to complete all forms.

Check List for Required Forms:

_____Health History

_____Medication List

_____Informed Consent

_____Financial & Cancellation Policies

_____HIPPA Consent

_____Authorization to Use & Disclose Protected Health Information

_____Credit Card Information

If you arrive to your initial appointment and you do not have all forms filled out, you will be required to fill them out prior to starting your evaluation. The amount of time it takes you to complete your forms will impact your treatment time.

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CURRENT HEALTH HISTORY

NAME _____ DOB _____ DATE

_____ ADDRESS _____ CITY_____

STATE _____ ZIP _____ CELL PHONE _____

WORK PHONE _____ PREFERRED E-MAIL ADDRESS

_____

IN CASE OF EMERGENCY _____ PHONE

_____

OCCUPATION_____

EMPLOYER_____ PRIMARY CARE

SPECIALIST_____ REFERRING PHYSICIAN_____

*****If you have referred yourself to physical therapy, Indiana state law requires a physician's order after 24 consecutive calendar days. (IC 25-27-1-2.5)**

1. **Describe the primary issue/problem that brought you here today:**
   _____
   _____.

2. **When did your problem first begin?**
   _____.

3. **Was your first episode of the problem related to an accident or specific incident? Yes/No**
   If yes, please describe:
   _____.
   _____ .

4. **Is your problem staying the same____, getting better____, getting worse____?**

5. **If pain is present, rate it on a 0-10 scale (0=no pain, 10=extreme pain):**
   _____At its worst _____At its best _____At present _____At night (sleeping)

6. **Please describe the nature of your pain (burning, stabbing, etc.):**
   _____ .

7. **Describe any previous treatments that you have received for this problem:**
   _____
   _____.

8. **Activities that cause/aggravate your symptoms:**
   Please check all that apply

___Sitting greater than _____minutes
___Walking greater than ____minutes
___Standing greater than ____minutes
___Changing positions (sit to stand)
___Vigorous activity (exercise/work)
___With triggers (key in the door, running water)
_____With cough, sneeze, straining
_____With laughing/yelling
_____With lifting/bending
_____Light activity (light housework)
_____With cold weather
_____With nervousness/anxiety

___Sexual activity (oral sex, manual stimulation, superficial penetration, deep penetration) ___Wearing tight clothing (underwear, tight pants, blue jeans, etc.)
___Inserting/attempting to insert a tampon
___Other, please describe_____. ___No activity affects the problem

9. **What relieves your symptoms?**
   _____
   _____.

10. **At what time of the day are your symptoms the worst?**
    _____.

11. **At what time of day are your symptoms the best?**
    _____.

12. **How has your lifestyle/quality of life been altered because of this problem?**
    _____
    _____
    _____.

13. **Rate the severity of this problem (0=no problem, 10=the worst)**
    _____.

14. **What are your treatment goals?**
    _____
    _____.

15. **What are your concerns, if any, related to this problem?**
    _____
    _____.

GENERAL HEALTH HISTORY

Date of last physical exam_____ who did you see_____? Where any tests performed? Yes/No _____.

General Health: Excellent Good Average Fair Poor

Mental Health: Currently seeing a psychologist/psychiatrist? Yes/No

Current level of stress: High Medium Low

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

What type of exercise _____?

Is your current problem/issue preventing you from exercising? Yes/No

Do you have discomfort, shortness of breath, or pain with exercise? Yes/No

Do you smoke? Yes/No

If yes, how many per day? _____ If yes, would you like to quit? _____ If no, did you smoke in the past? _____ **Is there a chance you may be pregnant now?** Yes/No

Sleep: Do you have trouble falling asleep? Yes/No

Is your sleep restful? Yes/ No

Do you find it difficult to lie down? Yes/ No

Do you find it difficult to change positions in bed? Yes/No

How many times do you wake per night? _____

How long before you fall back to sleep?_____

Have you ever had any of the following conditions or diagnoses? Please circle all that apply:

Cancer	Stroke Epilepsy/Seizures	Emphysema/Chronic Bronchitis
Heart problems	Multiple Sclerosis	Asthma
High Blood Pressure	Head injury	Allergies
Ankle	Osteoporosis	Latex sensitivity
Swelling	Hypothyroid/Hyperthyroid	Anemia

Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/drug problem	Arthritis	Kidney disease
Childhood bladder issues	Stress fracture	Irritable Bowel Disease
Depression	Rheumatoid Arthritis	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Bone fracture	Physical or Sexual Abuse	Vision/eye problems
Sports injuries	TMJ/neck pain	Raynaud's (cold hands & feet)
Pelvic pain	Hearing loss/problems	HIV/AIDS
Suicidal thoughts	Abortion	Liver disease

Other/describe_____

Surgical History:

Surgery for your back/spine	Yes/No	Surgery for your bladder/prostate	Yes/No
Surgery for your brain	Yes/No	Surgery for your bones/joints	Yes/No
Surgery for your abdominal organs	Yes/No	Surgery for your female organs	Yes/No

Other/please describe_____

Ob/Gyn History (females only):

Childbirth/vaginal deliveries #___	Yes/No	Vaginal dryness	Yes/No
Episiotomy #___	Yes/No	Painful periods	Yes/No
C-section #___	Yes/No	Menopause	Yes/No
Difficult childbirth	Yes/No	Painful vaginal penetration	Yes/No
#___ Pelvic pain	Yes/No	Prolapse/organ falling out feeling	Yes/No

Other_____

Males Only:

Prostate disorder	Yes/No	Erectile dysfunction	Yes/No
Shy Bladder	Yes/No	Painful ejaculation	Yes/No
Pelvic pain	Yes/No	Painful bowel movements	Yes/No

Medication List

Name: _____ DOB: _____ Date: _____

Medication	Purpose	Dosage/Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Vitamins/Supplements: _____

Allergies: _____

____ I do not take any medications, vitamins, or supplements.

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NAME _____ DOB _____DATE _____

INFORMED CONSENT FOR TREATMENT

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapists provide a wide range of services and I understand that I will receive information at the initial visit and throughout my therapy sessions concerning the treatment options available for my condition. Restore Your Core Physical Therapy is a hands-on physical therapy clinic and treatment consists primarily of manual therapy techniques. Forms of deep tissue therapy, myofascial release, bone and soft tissue manipulation, visceral manipulation, craniosacral modalities, neuromuscular re-education, therapeutic exercise, gait training, electrical stimulation, biofeedback, as well as other treatment modalities may be used. Some of the manual therapy techniques require deep pressure which may cause bruising and periods of soreness from 1-72 hours after treatment. Symptoms can also change and move to other areas of the body. Please ask if you have any questions or concerns. The number of treatments needed and recovery time will vary due to the age of the injury, number of times injured, age of the patient, overall health of the patient, and many other contributing factors.

Please read and initial beside each item:

_____I understand that I have the right to decline any portion of my treatment at any time before or during my session.

_____I understand that I may have another person in the room for any or all of my evaluation and treatment.

_____I understand that I am consenting to physical therapy performed by a licensed physical therapist, which may include internal pelvic evaluation of the muscles, organs, ligaments, and fascial structures.

_____ I acknowledge that I have the opportunity to ask questions and that all questions and concerns may be addressed to my satisfaction.

_____ I understand that treatment procedures involve both risks and benefits as indicated above.

I consent to physical therapy evaluation and treatment. I authorize Amy Robinson, PT, CLT, PRPC, WHNC and the fully trained staff to use treatment techniques as deemed necessary for my complete recovery. By initialing above and signing below, I acknowledge that I have read, fully understand and will abide by the policies noted on this consent form.

I have read and fully understand the above written statements.

X_____Date_____

Signature of patient/legal guardian (2081415v2)

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NAME _____ DOB _____ DATE _____

FINANCIAL AND CANCELLATION POLICIES

Welcome and thank you for choosing Restore Your Core for your Physical Therapy needs. Our mission is to provide specialized one-on-one physical therapy evaluation and treatment in a compassionate manner to enrich the lives of our patients. We have elected to no longer be a preferred provider for insurance companies due to the challenges associated with accepting insurance in the current healthcare environment. Instead, we provide physical therapy under a "fee at time of service" model. This means that payment is due at the time the services are rendered and we will *not* bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose to submit to your insurance company.

Your initial appointment will be billed at a slightly higher rate to include the cost of the initial physical therapy evaluation. The price for the initial evaluation will range between $175.00 - $225.00 depending on the complexity of your case, the time spent completing the evaluation, and the time spent on education and treatment.

•$175.00 - $225.00 for initial evaluation & treatment for 60-90 minutes. Your initial evaluation and treatment time is dependent upon the complexity of your case.

Follow Up appointments:

•$130.00 for 50 minute appointments

•$100.00 for 40 minute appointments

•$70.00 for 30 minute appointments

We accept cash, checks, HSA cards, and credit/debit cards at the time of service. Our fees are based on the services provided and the treatments performed during each appointment. The timely payment of your bill is an essential part of your treatment.

Cancellation Policy

As a courtesy to our Therapists and other patients waiting to be scheduled, **we require a 24-hour notice for cancellations.** This allows others on the waiting list to be seen in a timely fashion. Only emergencies and illnesses are excusable.

Please read below and initial beside each item:

_____I agree to pay for my evaluations and treatments at the time of service by cash, check, HSA card, or credit/debit card.

_____I understand it is my responsibility to contact my insurance company ahead of time, obtain any pre-authorization that is required, and obtain an estimate of my benefits. I understand that my therapist will provide me with receipts, upon my request, that is my responsibility to submit to my insurance company.

_____I understand I will be billed the **full amount** of the scheduled session if I do not show for my appointment or if I do not cancel within 24 hours of my appointment time.

_____I understand if I miss an appointment or do not cancel within 24 hours of my appointment, I will be billed the full cost of my appointment ***via my credit card which will be kept on file***. I understand it will not be accessed in any way except in the case of no-shows, cancellations, or at your request.

_____I understand that I will be given a reminder call or text 24 hours prior to my appointment. I understand that I cannot hold Restore Your Core accountable if I miss an appointment because I did not receive a reminder call or text as I am responsible for recording my appointments at the time they are scheduled.

_____I understand that Restore Your Core, LLC is not a participating provider with Medicare and that the therapist only provides services that are not covered under Medicare guideline (fitness, prevention, and wellness). I fully understand that I will not be able to submit my receipts to Medicare for reimbursement.

_____I understand that if I would like to transfer my records I will need to request in writing, and pay a reasonable copying fee if I want copies of my records sent to another doctor or organization. The amount of the fee is dependent on the number of pages that will be copied. I authorize Restore Your Core to include all relevant information, including payment history.

Additional Fees/Please read and initial beside each item:

_____A fee of $25.00 will be charged for any returned check.

_____A fee of $35.00-$50.00 (time dependent) will be charged for any paperwork your insurance requires your therapist to fill out.

I have read and fully understand Restore Your Core Physical Therapy LLC financial and cancellation policies and I agree to be bound by its terms. I fully understand that failing to initial any above bullet points does not excuse me from being bound by the policies outlined in this agreement.

X_____Date_____

Signature of patient/legal guardian

2081205v2

HIPAA Notice Acknowledgement & Consent

Restore Your Core Physical Therapy LLC

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office Restore Your Core Physical Therapy LLC and understand my rights contained in the notice.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for Restore Your Core Physical Therapy LLC ("RYC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. RYC reserves the right to revise its Notice of Privacy Practices at any time and will inform you if there has been an update to the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy officer, Amy Robinson, at 438 S. Emerson Ave., Suite 154, Greenwood, IN 46143.**

With this consent, RYC may (please check mark each box that you are consenting to):

- ☐ Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- ☐ Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked “Personal and Confidential.”
- ☐ Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- ☐ E-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that RYC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow RYC to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, RYC may decline to provide treatment to me.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

CREDIT CARD ON FILE AGREEMENT

PATIENT'S NAME: _____

CARDHOLDER INFORMATION:

Name on Credit Card: _____

Billing Address: _____

_____

Credit Card Type:

Please Circle: AMEX VISA MASTERCARD

Credit Card Number: _____

Exp Date: _____ Security ID: _____

Cardholder Signature: _____ Date: _____

I agree to keep my credit card information on file with Restore Your Core Physical Therapy LLC ("RYC PT") for unpaid balances, returned checks, or missed appointments (that have not been cancelled greater than 24 hours in advance per company policy).

2081509v2

Authorization to Use or Disclose Protected Health Information
Restore Your Core Physical Therapy LLC

1) Authorization

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

2) Patient Health Information authorized to be disclosed (Check one):

- ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR----

- ☐ I authorize the release of my complete health record with the EXCEPTION of the following information:
  - __Mental health records
  - __Communicable diseases (including HIV and AIDS)
  - __Alcohol/drug abuse treatment
  - __Other (please specify):_____

3) This Patient Health Information may be used for medical treatment, consultation, billing, or claims payment, or other purposes as I direct below:

_____

4) Choose One:

- ☐ **Effective dates** for this authorization: _____/_____/_____ through _____/_____/_____
  This authorization will expire at the end of the above period.

OR----

- ☐ All past, present, and future periods.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization at any time by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that signing this authorization is voluntary. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*

_____

Printed name of Patient or Patient's Authorized Representative