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**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_lbs

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Text Me Appointment Reminders: Y\_\_\_\_N\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Reason For Therapy/Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Inury or Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Tests: X-ray\_\_\_ MRI\_\_\_CT scan\_\_\_Bone density\_\_\_ EMG\_\_\_Blood test \_\_\_

Dates of Tests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering Physician(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You authorize THERx LLC access to the above tests to better assist us with treating you? Y\_\_\_N\_\_\_\_

Past Injuries/Surgeries with Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assistive Devices: None\_\_\_ Cane\_\_\_ Walker\_\_\_ Crutches\_\_\_WheelChair\_\_\_Brace\_\_\_Glasses\_\_\_\_

Do you have CANCER or have you had CANCER? Y\_\_\_\_N\_\_\_\_

Do you have a PACEMAKER/DEFIBRILLATOR? Y\_\_\_\_N\_\_\_\_

Are you PREGNANT? Y\_\_\_\_N\_\_\_\_

Are You DIABETIC? Y\_\_\_\_N\_\_\_

Do you have HTN? Y\_\_\_\_N\_\_\_\_

Do you experience DIZZINESS? Y\_\_\_\_N\_\_\_\_

Please list any other medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your pain from 0-10 and only circle one answer for each question. 0 is no pain and 10 is pain so severe that you have felt like calling or did call 911 to get you to the ER because it was that bad.

What is your CURRENT pain: 1 2 3 4 5 6 7 8 9 10

What is the WORST your pain has been: (past 48 hrs) 1 2 3 4 5 6 7 8 9 10

What is the BEST your pain has been: (past 48 hrs) 1 2 3 4 5 6 7 8 9 10

How would you describe the pain? Dull Achy Sharp Numb Tingling Burning Tight

When did your symptoms start? \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

How did your symptoms develop? Injury (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received other treatment for your current condition? Yes / No

If yes, what type of treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was it helpful? Yes /No

Have you ever had this condition before? Yes / No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What eases your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Indicate on the diagrams by placing an x in the areas you are experiencing pain/discomfort.



What are your goals/expectations? ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INFORMED CONSENT**

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals 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, massage, exercises, and physical agents to aid the patient in achieving a functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.*

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. THERx Physical Therapy and Pain Management LLC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

By signing below, you confirm that you have read this consent form and understand the risks involved in physical therapy and voluntarily agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

THERx

 Physical Therapy & Pain Management

800 Columbiana Dr Suite 50

Irmo, SC 29063

**Practice Policies**

 Please bring your valid prescription (dated within 30 days), ID, and insurance card to your first appointment. If you do not have the forms filled out prior to your first visit, please come 15 minutes early so that they can be completed before your scheduled appointment time. Even though the state of South Carolina has direct access to physical therapy, the number of sessions that is allowed without a prescription is 30 business days following your initial evaluation. If you don’t have a script, we ask that you place a call to your doctor’s office to request a script be sent to us at 803-828-3547. It should read “Physical Therapy Evaluate and Treat”. If this is a problem our therapist will be glad to place the call for you and send your initial evaluation over to be signed. Your insurance company requires a prescription before they will provide payment for services.

**Payment/Insurance**

All co-pays/co-insurance are due in full at the time of each session. We accept cash, check and credit cards. Co-pays are constant and co-insurance varies for each insurance policy. Medical insurance coverage is a contract between you and your insurance company and we are not a party to this contract. We will not be involved in disputes between you and your insurance company other than to supply factual information as necessary. At THERx Physical Therapy & Pain Management, we make every effort to verify your insurance benefits prior to your first appointment in order to make you aware of your estimated cost per visit. Please note that this is only an estimate of what you may owe after insurance is paid. We have done our best to outline your plan below. However, it is the policy holder’s responsibility to understand his/her individual coverage. If your insurance carrier denies payment for services rendered, or your plan becomes inactive while receiving treatment, YOU may be responsible for the cost of services. Your signature below indicates that outstanding balances over 90 days can be processed by a collection agency.

**Treatment Sessions**

An initial evaluation includes a thorough assessment provided by a Dr. of Physical Therapy and treatment lasting from 60-75 minutes. Follow up visits typically last 45-60 minutes. For your evaluation and each follow up visit, please wear or bring clothes that are appropriate for exercise and that allow us to treat at and around the affected area. (Such as shorts, yoga pants or sweat pants and tee shirt or tank top).

**Medical Information/Medical Records**

We understand that your present and past medical information is personal. We are committed to protecting information about you. We create a record of care and services you receive at THERx Physical Therapy & Pain Management LLC that is maintained electronically via WebPT. This allows for us to remain free of paper charts, that are prone to damage, loss, or security concerns. We need these records to provide you with quality care, to comply with legal requirements and to meet your needs for reimbursement. This notice applies to all of the records generated: law to requires us:

a. Make sure that medical information that identifies you is kept secure.

b. Give you this notice of our legal duties and privacy practices with respect to medical information about you. By signing below, you are giving THERx permission to request medical records from other offices that may help in providing you with more appropriate and accurate care. Such reports may include diagnostic tests or surgical records performed at a facility in which you the patient releases to us.

**Tardiness/Cancellations/NoShows**

We ask that you arrive on time for your appointments and that you are considerate of the next patient’s time when your session ends. If you arrive late your treatment time will be shortened. If you are running behind, be courteous and give us a call at **803-609-0100.**  Please give us **24 hours** notice if you are unable to keep your appointment. Failure to give a 24 hour notice will result in a **$25.00 fee** that must be collected before any further services will be rendered. No shows will also result in a **$50.00** charge. We understand that emergencies do happen and will make every effort possible to reschedule your appointment, but we must be notified in order to do so.

By signing below, I certify that I have read the above policies, understand, and will comply with them. I agree that THERx Physical Therapy & Pain Management has the right to cancel any future appointments in the event of a late cancellation or no show activity, as described above.

Signature of Patient or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

THERx Physical Therapy & Pain Management LLC

800 Columbiana Dr Suite 50

Irmo, SC 29063

**HIPAA Policy & Privacy Practices**

**THERx Physical Therapy & Pain Management LLC**

**Patient Health Information (PHI)**

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

**How we use your patient health information (PHI)**

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

**Treatment:** We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

**Payment:** We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

**Operation:** We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor’s office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

**Special Situations that DO NOT require your permission:** We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker’s compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

**Individual Rights**

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

**Our Legal Duty**

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.ProgressivePhysicalTherapy.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

If you have any questions, requests, or complaints, please contact:

**THERx Physical Therapy & Pain Management LLC**
Attn: Privacy Officer
800 Columbiana Dr
Irmo, SC 29063

Contact: [Privacy Officer](http://pptaccess.com/patients/hipaa_form.htm)

**HIPAA South Carolina**
US DHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth Street
Atlanta, Ga. 30303-8909

I understand that a patient’s health information is private and confidential. I understand that THERx has procedures to protect a patient’s privacy and preserve the confidentiality of every patient’s personal health information. I will assist THERx by following these procedures if I choose to exercise any of my rights described in the “Notice of Privacy Practices.”

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Effective 1/1/16