Please initial that you have read each section and sign at the bottom

____ **Cancellation/No-Show Policy:** *Paradigm Physical Therapy requires 24 hour notice for the cancellation of a scheduled appointment. There is a $50.00 charge for a No-Show or Cancellation without proper notice. This charge will not be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "Two Cancel and/or No Show" policy. We will allow for two cancellations before charging a fee.* **For every cancellation or no-show beyond two, a $50.00 fee could be assessed.** *Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no-shows will hinder your care and may result in discharge from our clinic.*

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available; however, simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 10 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. *You, the patient – for not receiving the treatment you need.*
2. *Your therapist – as now he or she has a gap in the schedule.*
3. *Another patient – who could have had your appointment time.*

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

____ **Scheduling Policy and Patient Consent:** *I do hereby give consent to Paradigm Physical Therapy & Wellness to perform Physical Therapy, to release any medical and billing information necessary to process insurance claims for my medical services, and I give permission to fax and release medical information to my referring Medical provider and any Medical provider involved in the care of my present condition. I also permit a copy of the authorization to be used in place of the original.* **Minor children under the age of 14 must be accompanied by a parent or guardian during their treatment time.** *In the case of Minor children 14 years or older that are dropped off or transport themselves, my*

parental signature below authorizes continued treatment and releases Paradigm of any liability for the transportation period to and from our clinic.

____ **Refund Policy**: *Due to the uncertainty of deductible, co-pay, and co-insurance amounts due at the time of service, Paradigm Physical Therapy may collect in error for these amounts. A reconciliation of your account will occur 30 days after treatment has ended and 30 days after all payments are received from insurances. A refund will be issued within 30 days of your account reconciliation. Special circumstances will be reviewed on a case by case basis.*

____ **Acknowledgement of Privacy Rights:** *My signature confirms I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used to:*

- *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers for my health care services.*
- *Conduct normal health care operations such as quality assessment and improvement activities.*

Will there be anyone other than yourself that you would like to give permission to have and handle the following aspects of your care? ☐No ☐Yes, Name(s): ____________________________________

____

- *Access to my financial information, in order to pay any deductible, co-insurance or copay payments or any other payments on my account.*
- *Ability to schedule, cancel and/or discharge therapy appointments.*
- *Ability to acquire information from the Physical Therapist or Physical Therapy Assistant regarding my treatment at Paradigm.*
- *Any other information specified by patient. Please list below:*
  ____
  ____

Emergency Contact: ___________________________________*Ph#:*___________________________

I understand I must be notified in writing of any changes in disclosures or restrictions of information other than stated above.

I have read the above policies and do agree to the terms.

____ _________________________

Patient/Guardian Signature **Date**

Past medical history (check all that apply):

- ☐ *Heart Disease*
- ☐ *Heart Attack*
- ☐ *Heart Surgery*
- ☐ *Angina*
- ☐ *COPD*
- ☐ *CVA/Stroke*
- ☐ *TIA*
- ☐ *High Blood Pressure*
- ☐ *Asthma or Pulmonary Disease*
- ☐ *Diabetes*
- ☐ *Ulcer or Stomach Disease*
- ☐ *Bowel Disease*
- ☐ *Kidney Disease*
- ☐ *Liver Disease*
- ☐ *Anemia or other blood disease*
- ☐ *Overweight*
- ☐ *Cancer*
- ☐ *Depression*
- ☐ *Osteoarthritis*
- ☐ *Rheumatoid Arthritis*
- ☐ *Osteoporosis/Penia*
- ☐ *Back Pain*
- ☐ *Lyme Disease*
- ☐ *Bronchitis*
- ☐ *Seizures*
- ☐ *Allergies*
- ☐ *Headaches*
- ☐ *Rheumatic Fever*
- ☐ *Sexually Transmitted Disease*
- ☐ *Alcoholism*
- ☐ *Hearing, vision, speech, and/or communication problems*
- ☐ *Surgery:____*

Are your symptoms:

- ☐ *Getting worse*
- ☐ *The same*
- ☐ *Improved*

Are you currently?

- ☐ *Pregnant (female patients only)*
- ☐ *Under stress*
- ☐ *Depressed*

Date of last physical exam:

____

In general, how would you say your health is?

- ☐ *Excellent*
- ☐ *Very good*
- ☐ *Good*
- ☐ *Fair*
- ☐ *Poor*

Do you work out?

- ☐ *Not at all*
- ☐ *Light: 1-2 times/week*
- ☐ *Moderate: 3-4 times/week*
- ☐ *Heavy: 4-6 times/week*

In the past 3 months have you had?

- ☐ *A change in your health*
- ☐ *Nausea or vomiting*
- ☐ *Fever, chills, or sweats*
- ☐ *Unexplained weight changes*
- ☐ *Numbness or tingling*
- ☐ *Changes in appetite*
- ☐ *Difficulty swallowing*
- ☐ *Changes in bowel/bladder function*
- ☐ *Urinary tract infection*
- ☐ *Shortness of breath*
- ☐ *Dizziness*
- ☐ *Upper respiratory infections*

Do you or have you ever smoked or chewed tobacco? □*Yes* □*No*

Do you drink alcohol? □*Yes* □*No*
If yes, how many drinks do you have on average per week?

____

Highest level of education completed…

- ☐ *Less than high school*
- ☐ *Graduated from high school*
- ☐ *Graduated from college*
- ☐ *Postgraduate school or degree*

List all medications currently taking:	Dosage:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
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