ALIGN
PHYSICAL THERAPY
AND WELLNESS

PATIENT INFORMATION

First Name_____MI_____ Last_____Preferred Name_____
Date of Birth____/_____/_____ Age _____ Gender_____Today's Date_____
Street Address_____
City_____ State_____Zip Code_____ Profession_____
Primary Phone_____home/cell/work
Alternate Phone_____home/cell/work
Email Address_____
Emergency Contact Name_____ Phone_____
Relationship_____
How did you hear about Align PT_____
How would you like to receive courtesy appointment reminders? email/phone/decline reminder
Primary Care Provider_____ Phone_____
Medical Diagnosis or Primary Concern_____
_____date of onset_____
Was the onset related to a specific incident? Y?N, if Yes, please describe:_____
_____
Are the symptoms staying same/ getting worse/ getting better? (circle one)
Please rate your pain, if present, on a scale 0-10 (0= no pain, 10= emergency room) _____
Have you had an x-ray, MRI, or other imaging recently? Y/N (if yes, please describe)
_____
Have you tried other treatments? Y/N, please describe_____
_____
What activities aggravate symptoms? _____
What relieves your symptoms?_____
How has your lifestyle been altered because of this?_____
_____
What are your treatment goals?_____
_____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of Align Physical Therapy and Wellness, LLC to administer evaluation and treatment necessary and advisable for my condition. If patient is a minor, a parent or guardian must sign. **Consent must be signed before we begin treatment.**

_____ _____
Signature of Patient (or Legal Guardian) Date

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MEDICAL HISTORY

Since onset of current symptoms, have you had any of the following:(circle all that apply)

Fever/chills	Change in bowel function	Numbness/tingling
Unexplained weight change	Change in bladder function	Night sweats
Dizziness or fainting	Fatigue or unexplained weakness	Nausea/vomiting
Blood in urine or stool	Swelling or lumps anywhere	Difficulty swallowing
Difficulty Speaking	Jaw Pain, teeth grinding	Incontinence
Cough	Skin Rash	Falls

Have you ever had any of the following conditions: (please check all that apply)

	Allergies (list below)		Eating disorder		Hypoglycemia
	Angina or chest pain		Epilepsy/Seizures		Hypo/hyper Thyroid
	Anxiety/panic attacks		Fibromyalgia		Joint Replacement
	Anemia		Fracture		Latex Sensitivity
	Arthritis		GERD/ulcers		Multiple Sclerosis
	Asthma or other breathing problems		Gout		Osteoporosis
	Cancer		headaches		Parkinson's
	Chemical Dependency (drugs/alcohol)		Heart problems		Pelvic Pain
	Chronic Fatigue Syndrome		Hepatitis		Scoliosis
	Cirrhosis/liver disease		High blood pressure		Sexual or physical abuse
	Depression		High Cholesterol		Sleep Apnea
	Diabetes		HIV/AIDS		Stroke

	Hearing loss/problems		Vision/eye problems		Urinary Problems

Other (list allergies here):_____

Surgical History: (please include all)

_____

_____

Do you have a pacemaker, transplanted organ, or implant? Y/N_____

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Female OB/GYN History:

childbirths_____ episiotomy Y/N menopause Y/N incontinence Y/N

vaginal deliveries_____ prolapse Y/N painful vaginal penetration Y/N

caesarian deliveries_____ painful periods Y/N pelvic pain Y/N

Other:_____

General Health: Excellent Good Average Fair Poor (please circle)

Work hours/week_____ Are you restricted in work activity? Y/N_____

Sleep hours/night_____ Is your sleep disrupted by your symptoms?_____

Are you on a special diet? Y/N _____Do you smoke tobacco? Y/N

How many alcoholic drinks do you consume per week? _____

How much caffeine (coffee,tea, chocolate, soda) do you consume daily? _____

Mental Health: Current level of stress: High Medium Low (please circle)

What do you do to relieve stress? _____

Have you tried meditation? Y/N

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

Type of exercise:_____

Medications (including supplements): Start Date Reason for Taking

_____

_____

_____

_____

_____

_____

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SCHEDULING AND CANCELLATION POLICY

When canceling a scheduled appointment, we require patients to notify our office by phone 48 BUSINESS HOURS prior to the scheduled appointment time. If you cancel an appointment within 48 BUSINESS HOURS prior to the scheduled appointment time and can not reschedule within the next 2 weeks, there is an automatic CANCELLATION FEE applied to the patient account. The charge for a LATE CANCELLATION OR NO-SHOW FEE is $40.00. There is no charge if you are able to reschedule within a 2 week time frame.

_____ _____

Signature of Patient (or Legal Guardian) Date

FINANCIAL POLICY

This is an agreement between Align Physical Therapy and Wellness, LLC as creditor, and the patient/debtor named on this form. In this agreement the words 'you', 'your', and 'yours' mean the patient/debtor. The words 'we', 'us' and 'our' refer to Align Physical Therapy and Wellness, LLC. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: We accept credit/debit card, cash, check and FSA/HSA cards. Unless other arrangements are approved in writing, the payment for your services is due at the time of service and is past due if not paid by the subsequent treatment session. You will need to pay all past due amounts before receiving subsequent treatment intervention. Failure to pay account in full within 90 days of date of service will result in turning your account over to a collection agency.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Signature of Patient (or Legal Guardian) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been informed of and given the right to review and secure a copy of Align Physical Therapy and Wellness, LLC's Notice of Privacy Practices.

_____ _____

Signature of Patient (or Legal Guardian) Date

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CONSENT FOR EMAIL COMMUNICATIONS

I, the undersigned, give permission to the practitioner/s of Align Physical Therapy and Wellness, to communicate with me via email. I understand that Align Physical Therapy and Wellness cannot guarantee the security of Protected Health Information (PHI) via email.

___ Yes, I give consent to use email for Office Communications (appointment reminders, newsletters, communication with PT/staff only).
___ I do not give consent to use email for any purpose.

_____ _____
Signature of Patient (or Legal Guardian) Date

CONSENT FOR ELECTRONIC INVOICES AND/OR STATEMENTS

___ YES, please send all invoices and account statements by EMAIL.
____DECLINE, I prefer to receive invoices and account statements by postal mail.

By opting for electronic invoicing, patients grant Align Physical Therapy and Wellness permission to send invoices for account balance(s) as well as current and past account statements by electronic delivery to the designated e-mail address specified below. Examples of electronic invoicing include but are not limited to: documentation required by health savings and/or reimbursement accounts, payment receipts, current account balance, outstanding balance due. By accepting these Terms and Conditions, you are confirming that you have access to a computer and/or printer. Please read the following Authorization and Consent disclosure before accepting and agreeing to this disclaimer. A copy of this authorization will be provided to you by request only.
Payments can be made by cash/check/credit card in person or by check via postal mail.

By signing below you agree to inform our office of any **changes** in your **telephone number, mailing address, or designated e-mail address.** Notification of the changes listed above can be made by telephone call or written notice by postal mail.
You will receive an electronic invoice when a balance is due for your account. **Payment is due upon receipt of your electronic invoice.**

I hereby give permission to the practitioner/s of Align Physical Therapy and Wellness, to deliver account invoices and/or requested statements by e-mail to the designated e-mail address specified below. I understand that Align Physical Therapy and Wellness cannot guarantee the security of Protected Health Information (PHI) via e-mail. Your information will not be intentionally distributed to any outside parties.

Designated e-mail _____

_____ _____
Signature of Patient (or Legal Guardian) Date