DEXTER
PHYSICAL THERAPY

Patient Information			
Last Name First		Date of Birth	
Email		Cell Phone	Home Phone
Street Address		City, State	Zip
Occupation & Employer	Referring Physician and/or PCP	Dr.'s phone #	
Insurance (I do not bill directly)			

Emergency contact		
Name	Relationship	Phone number

Acknowledgement of receipt of Privacy Practices Notice (HIPPA)	
I acknowledge that I have received a copy of Dexter Physical Therapy's Notices of Privacy Practices. This notice provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed this notice.	
_____	_____
Signature of Patient or Guardian	Date

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Name_____ Today's Date _____

Primary complaint/concern _____

Date of Onset or describe progression _____

Describe your symptoms in your own words _____
_____

My symptoms are ____ constant ____ intermittent

Do your symptoms have a 24 hour pattern (worse in the morning or at night) or are the symptoms worse based on what activities you do?_____
_____

What makes your symptoms worse? _____
_____

What makes your symptoms better? _____
_____

Any numbness, tingling or feeling of weakness? _____

What are you unable to do or cautious doing because of your symptoms?
_____

Have you had other treatment (physical therapy, acupuncture, chiropractic, massage)?
_____

Have you had an imaging (X-ray, CT scan, MRI, Ultrasound)? If so what were the results? Please provide a copy of the written report if you have it._____
_____

Sports and recreational activities _____

Stress level on average (0 = no stress, 10 = very high stress) _____

Goals for Physical Therapy _____

Medications, Vitamins (can bring in list) _____

Allergies _____ Surgeries _____

Medical History

	No	Yes		No	Yes
Arthritis			High cholesterol		
Asthma			Memory issues		
Bowel/bladder changes			Night pain		
Broken bones (fractures)			Osteoporosis/osteopenia		
Cancer			Pacemaker		
Concussion			Pain with toileting or intercourse		
Depression or bipolar			Pregnant		
Dizziness			Previous abuse, trauma, accidents, falls		
Fibromyalgia or Chronic Fatigue Syndrome			Shortness of breath		
Headaches			Stroke or TIA		
Hearing loss or ringing in the ears			Thyroid problems		
Heart attack			Unexplained weight change		
Heart disease			Vision changes		
High blood pressure					

Consent for Treatment
As a patient you have the right to be informed about your health condition and recommended rehabilitation treatments. This document provides information you may use to decide whether to give or withhold your consent to be provided care at Dexter Physical Therapy, PLLC.

I, _____ (print name), request and consent to examination and treatment for Physical therapy. I understand I have the right to ask questions about:

- all aspects of examination and treatment, my condition, diagnosis and prognosis
- the goals and benefits or proposed care
- inherent risks, complications, or side effect of treatment
- the likelihood of improvement and success following treatment
- reasonable and available alternatives to the suggested care

Nature and character of treatment
I understand that physical therapy may involve the following:

- assessment of vitals (heart rate, blood pressure, respiratory rate)
- neuromusculoskeletal examination involving testing of reflexes, sensation, strength
- movement exam of trunk and limbs
- palpation and mobilization and of soft tissues and joints
- instruction in therapeutic exercises and neuromuscular training to improve my condition
- application of heat, cold and electrical stimulation
- body mechanics instruction

Potential Risks
I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary. If it does not subside in 24 hours I agree to contact my physical therapist at Dexter Physical Therapy, PLLC.

Potential Benefits
I may experience an improvement in my symptoms and an increase in my ability to preform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

Email Consent
Dexter Physical Therapy, PLLC, allows patient to communicate via email. Electronic communication poses inherent risks and this consent acknowledges that I have been advised of the following:

- Email is not appropriate for urgent health matters or for emergencies
- Shared email accounts or computers can compromise privacy
- Email may not be confidential as it can be viewed by employers or by system operators
- Email may not be returned promptly when clinician is away from the office. Contact your primary care doctor, urgent care or emergency department in the event of a significant change in condition
- Email correspondence will become part of the medical record.
- In-person communication should be use if concerned about privacy
- Consent may be revoked at anytime by contacting Dexter Physical Therapy
- Email correspondence for patients 18 years of age or older
- Dexter Physical Therapy, PLLC is not liable for information that is unintentionally disclosed

CANCELLATION POLICY

Appointments which are missed or cancelled ***less than 24 hours*** in advance will result in a ***$70*** charge.

- Special situations, such as emergencies, may be exempt.
- Cancellations may be done via email or phone.
- It is your responsibility to know when your appointment is. The automated service which may send reminders can sometimes fail so do not rely on this solely.
- If there are more than 3 no shows, late cancellations or late arrivals to appointments we reserve the right to cancel upcoming appointments and offer them to patients who are able to attend consistently.

Payment

I have reviewed the fees and acknowledge that payment is required at the time of service and that I am financially responsible for the balance. I understand it is my responsibility to contact my insurance to understand my benefits and obtain pre-authorization if necessary. Dexter Physical Therapy, PLLC will not bill my insurance, but upon request will provide a receipt which may be submitted to my insurance for reimbursement. I authorize Dexter Physical Therapy to release any information required to process my payment.

Each Visit: $130

I read the above information and consent to physical therapy evaluation and treatment.

_____	_____	_____
Patient Name or guardian(print)	Signature of patient or guardian	Date