Patient Information & Consent Form

Welcome to Active Fitness & Physical Therapy

Please fill this form out as completely as possible.

Full Name:_____I prefer to be called: _____Today's Date: _____

DOB: _____/_____/_____ Age: ____ ____ Social Security #: _____

Home Address: _____City_____State_____ Zip _____

Home Phone #: ( ) _____ Cell #:_____Work Phone #: _____

Employer: _____ How Long There? _____ Occupation: _____

E-mail address: _____ Driver's License #: _____

Would you like to be notified of your appointments by Email _____ Text_____ (Please select one or both)

Do we have your permission to leave a message on your voicemail? Yes_____ No_____ (Please check one)

EMERGENCY CONTACT – RELATIVE OR NEIGHBOR

Name: _____ Relation: _____ Home Phone: _____ Cell Phone: _____

Address: _____

CONSENT OF DISCLOSURE

I hereby give consent to Active Rehab Services DBA Active Recovery Physical Therapy and all health care providers furnishing care within Active Recovery to disclose my protected health information for the purposes of treatment, payment, and health care operations. Our posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. Including how to restrict usage of your information, request cancellation of consent, request your medical record be amended or request a copy of your records. You have the right to review our posted policy before you sign this consent.

I acknowledged I have received a copy of Active Rehab Services Patient Privacy Policy.

I, _____, authorize health care providers and administrative staff of Active Rehab Services to discuss my personal health information with the following persons:

Spouse _____ Children_____

Parent _____ Other _____

Signature: _____ **Date**: _____

If you are signing as the patient's representative: Name (please print): _____

Signature: _____ Relationship to patient: _____

OVER→

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. Treatment may include Manual Therapy, Massage Therapy, Dry Needling, Therapeutic Exercise Programs and Modalities such as Electrical Stimulation, Ultrasound, Class IV Laser, as well as diagnostic testing including Musculoskeletal Ultrasound, EMG/NCS testing. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Active Rehab Services DBP Active Fitness & Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if "hands-on" manual or exercise techniques that are being used to retrain, recruit and restore normal function are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed one year.

I _____have read this form and fully understand and accept its terms and conditions.

_____ _____

Patient signature or Person Authorized to consent for Patient Date