MICKOW CE PHYSICAL THERAPY, LLC

Informed Consent

I hereby request and consent to treatment or services to be performed by Mickow CE Physical Therapy, LLC and give the treating party permission and authority to treat me in ways that are determined to be beneficial to me based on diagnostic testing and functional movement analysis. I understand that the results are not guaranteed and responses to intervention are individualistic in nature. I am aware that there are some risks to treatment and that I may request to terminate a session, decline intervention, and discuss or ask questions at any time during treatment. It is the responsibility of the patient to disclose any underlying physical defects, illness, or deformities that may not otherwise come to the attention of the treating party and that may render the patient susceptible to injury. The treating party will not provide treatment if he/she is made aware of adverse conditions as stated above. My signature below certifies that I have read and understand the above information regarding informed consent.

Release of Information, Financial Responsibility, and Assignment of Benefits

I give permission to Mickow CE Physical Therapy, LLC to release information, written and verbal, contained in my medical record, and other related information, to my insurance company, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries as it relates to my treatment and/or payment for services provided. I authorize Mickow CE Physical Therapy, LLC to obtain medical records and/or professional information as it relates to my treatment and/or medical benefits. I have insurance and/or employee health care benefits as states on the patient information form. I agree to pay any applicable co-payments or co-insurance at time of service. I understand that I am responsible for any charges not covered by my health insurance or third-party payer. I understand that I may opt out of using insurance coverage at any time and that cash payment in the form of cash, check, or credit card, are due at the time of service. I authorize payments directly to Mickow CE Physical Therapy, LLC of medical benefits and/or insurance reimbursement for services rendered. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. My signature below certifies that I have read and understand the above information regarding release of information and assignment of benefits.

Notice of privacy practices

I have reviewed the notices of privacy practices (HIPPA). I will be given a copy of the privacy practices upon request. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment and payment.

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Disclosures to Specific Family Members and/or Friends

I authorize Mickow CE Physical Therapy to disclose protected health information to the individuals named below to allow those named below to participate in my plan of care with more understanding:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Attendance and Cancellation Policy

I agree to fully participate and comply with my plan of care including timeliness of my arrival to therapy appointments to maximize my recovery potential. I agree to provide a minimum of 24 hours' notice when cancelling or rescheduling appointments. I understand that poor attendance limits my own rehabilitation program and keeps other patients from accessing appointment times. I accept that Mickow CE Physical Therapy reserves the right to discontinue therapy services due to repeated cancellations, no-shows, or late attendance per the discretion of the physical therapist. My signature below certifies that I have read and understand the above information and agree to a cancellation or no-show fee of $100 if notice is not provided 24 hours in advance.
No refunds will be provided. Potential credits towards other Elite therapies will be provided if warranted.

Miscellaneous

I acknowledge and accept any risk associated with communication via phone, text, or email between Mickow CE Physical Therapy, LLC and patient should I choose to use this as a means of communication.

I have read, understand, and agree to the terms and conditions outlined above and consent to all necessary treatment as determined by Mickow CE Physical Therapy, LLC.

Printed Name Patient/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Relation to Patient: _____

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Credit Card Authorization Form

Credit Card information is required to secure an appointment with Mickow CE Physical Therapy, LLC

Full Name: _____Today's Date: _____

Credit Card Information

Name on Card: _____

Relationship to patient: _____

Phone Number: _____

Billing Address: _____

Account #: _____

Expiration Date: _____

CVV Code: _____

Credit Card Authorization:

I authorize Mickow CE Physical Therapy, LLC to charge my credit card for insurance co-payments at the time of service, any balance owed after review of your final insurance payments, and to cover any late cancellations or no-show fees. I further understand that this form will be attached to my permanent records and can be used for all future treatment. It will be kept confidential and not divulged to any outside party.

I, _____ , hereby authorize Mickow CE Physical Therpay, LLC to charge my credit card.

Signature: _____ Date:_____

Printed Name: _____

MICKOW CE PHYSICAL THERAPY, LLC

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Birth Date: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I wish to receive messages containing health information (Circle): Yes No

Preferred Method of Communication (Circle): home cell work text email other

Marital Status (Circle): single married/divorced widowed separated partnered other

Occupation: _____

Employment Status: active duty full-time part-time retired student none

Referral Source (i.e. doctor, family, friend, trainer): _____

In case of emergency, please notify-

Name: _____

Relationship: _____

Phone Number: _____

If Applicable-

Parent/Guardian Name: _____

Parent/Guardian phone number: _____

MICKOW CE PHYSICAL THERAPY, LLC

Reason for Visit: _____

Is this injury related (Circle: Yes No

If yes, nature of the injury (Circle): automotive work-related personal sports/activity other

If other, please describe: _____

If yes, is an attorney involved (Circle)? Yes No

Date of injury: _____

Primary Insurance

Name of insured party: _____

Date of Birth of Insured: _____

Relationship to Insured: _____

Insurance Company: _____

Secondary Insurance

Name of insured party: _____

Date of Birth of Insured: _____

Relationship to Insured: _____

Insurance Company: _____

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Patient Intake Form

Past Medical History (Circle all that apply)

Heart dysfunction	Parkinson's Disease	Pregnancy
Heart Attack/CABG	Multiple Sclerosis	current
Cholesterol dysfunction	Unexplained weight loss	history
High blood pressure	Sleep disorder	Cataracts/glaucoma
Chest pain/angina	Chronic pain	Macular Degeneration
Circulatory issues	Fibromyalgia	Other visual deficits
Shortness of breath	Thyroid (hypo/hyper) dysfunction	Anxiety
Lung disease	Stomach disorders	Depression
Asthma	Kidney disease	Osteoporosis
Chronic obstructive pulmonary disease (COPD)		Osteopenia
Active/history of cigarette use	Infectious disease (circle)	Osteoarthritis
Active/history of alcohol use	TB/HIV/AIDS/Hepatitis	Rheumatoid arthritis
Head trauma	other	Psoriatic arthritis
Concussion	Cancer	Back injury
Stroke	Bowel issues	Neck injury
Dizziness/vertigo	Bladder issues	Fractures
Seizures/epilepsy	Diabetes (type I, type II)	Metal implants
Joint replacements	Hypersensitivity hot/cold	Joint dislocations
Balance issues	Hernias	Left or Right-handed

Disability: _____

Allergies (including latex): _____

Past surgeries: _____

List Medications or Circle See attached: _____

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Communication

Do you need any assistance with communication? Yes No

If yes, please explain: _____

Living Situation

Do you live alone? Yes No If no, who lives with you? _____

Style of home: _____

Does your home have stairs? Yes No If yes,

are they inside, outside, or both? How many stairs at each location? _____

Work/Social History

Occupation requirements/duties: _____

Hobbies/sports/community involvement: _____

Level of function prior to injury: bedridden sedentary limited activity active

Level of function currently: bedridden sedentary limited activity active

Current Problems with Gross Motor and Activities of Daily Living:

Communication	Personal care	Balance	Stairs (up or down or both)
Swallowing	Home management	Walking	Driving
Falls			

If applicable, how many falls in the last year?_____ Last month? ____ When was most recent? _____

Do you use any assistive devices for mobility? Yes No

If yes, what devices? _____

Your Goals

What do you need to be able to do again that you are limited from doing because of the issue(s) for which you are coming to therapy? _____

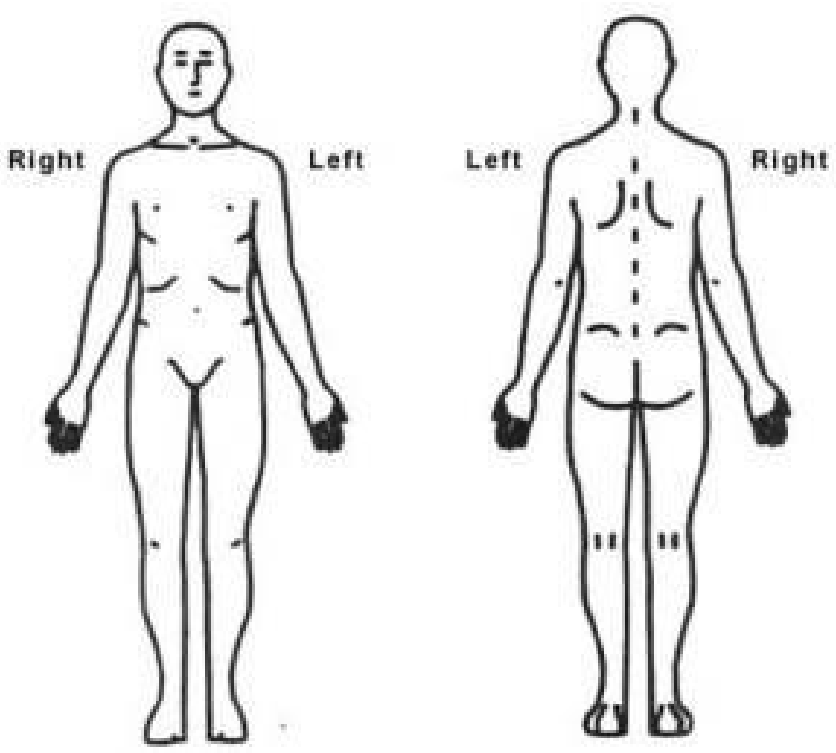
Chief Complain/Limitations

_____

Precautions/Restrictions/Additional Information:

MICKOW CE PHYSICAL THERAPY, LLC

Pain Diagram



Quality of pain (circle all that apply):

Sharp Burning Dull Achy Radiating

Non-radiating Cramping Constant Intermittent

Verbal analogue scale:

0 1 2 3 4 5 6 7 8 9 10

Wong-Baker FACES pain scale:

Have you identified any exacerbating factors? _____

Have you identified any alleviating factors? _____