ELEVATION

PHYSICAL & OCCUPATIONAL THERAPY

FULL NAME: _____ HOME PHONE: _____

CELL PHONE: _____

EMAIL: _____ WORK PHONE: _____

MAILING ADDRESS: _____

_____

SSN: _____ DOB: _____ EMPLOYER: _____

REFERRING MD: _____ PRIMARY PHYSICIAN: _____

ARE YOU RECEIVING OR HAVE YOU RECENTLY RECEIVED ANY HOME HEALTH OR OTHER THERAPY SERVICES? YES / NO

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: (H) _____ (W) _____ (C) _____

DO YOU HAVE/HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CIRCLE YES (Y) OR NO (N):

HEART PROBLEMS	**Y**	**N**	PREGNANT	**Y**	**N**	SMOKER	**Y**	**N**	SEIZURES	**Y**	**N**
HIGH BLOOD PRESSURE	**Y**	**N**	DIABETES	**Y**	**N**	DEPRESSION	**Y**	**N**	HIV/AIDS	**Y**	**N**
PACEMAKER	**Y**	**N**	CANCER	**Y**	**N**	OSTEOPOROSIS	**Y**	**N**	STROKE	**Y**	**N**

LIST ALL CURRENT MEDICATIONS THAT ARE NOT OVER THE COUNTER MEDICATIONS (EX. HYDROCODONE 7.5 MG):

_____

_____

BODY PART TO BE TREATED: _____ DATE OF INJURY: _____

BREIFLY DESCRIBE HOW THE INJURY HAPPENED: _____

_____

TYPE OF INJURY (CIRCLE ONE): AUTO ACCIDENT / WORK COMP / OTHER (SPECIFICY) _____

IF AUTO PLEASE COMPLETE THE FOLLOWING: AUTO INSURANCE NAME: _____

ATTORNEY NAME: _____ ATTORNEY PHONE NUMBER: _____

IF WORK COMP PLEASE COMPLETE THE FOLLOWING: EMPLOYER NAME: _____

WORK COMP CASE MANAGER NAME: _____ CASE MANAGER NUMBER: _____

YOUR JOB TITLE: _____ WORK STATUS: FULL TIME / PART TIME / MODIFIED / OFF / RETIRED

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I **consent to rehabilitation** and related services at Elevation Therapy LLC. In so doing, I understand and acknowledge and that such rehabilitation and related services will involve direct bodily contact, hands on treatment, and/or close contact.

If applicable, I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so

By signing this form, you are granting consent to Elevation Therapy LLC to use and disclose your protected health information and electronic protected health information to a third party (i.e., referring doctor, case manager, parent or legal guardian, etc.) strictly for the purposes of treatment, payment, and health care operations. Elevation Therapy LLC will not disclose your protected health information without your consent. The Notice of Health Insurance Portability and Accountability Act of 1996 provides more detailed information about how we may use and disclose this protected health information. It is your right to review our Notice of Privacy Practices before you sign this consent and may ask to read it in full at any time.

Elevation Therapy LLC's Notice of Privacy Practices is subject to change and you have the right to request the revised notices by contacting us.

You have the right to request a restriction of how your protected health information is used. Elevation Therapy LLC is not required to agree to the request but if the clinic does agree we must follow these restrictions.

You have the right to revoke this consent in writing at any time, however Elevation Therapy LLC may still use this information to complete any actions that began prior to you revoking consent. Elevation Therapy LLC may refuse your services if you refuse to sign this contract. With this consent Elevation Therapy LLC may call/text my home or other alternative phone numbers and leave a message on voicemail or to any person answering the phone in reference to any items that assist the office in carrying out treatment, payment, and health care operations; such as appointment reminders, insurance items and any calls pertaining to my clinical care.

If you wish to release your health information to anyone other than those already involved in your medical care (i.e., referring doctor, case manager, parent or legal guardian, etc.) please specify below:

Name of person or organization: _____

Telephone number: _____

Relationship to patient: _____

_____ _____

Signature of patient, guardian or representative **Date**

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PHYSICAL & OCCUPATIONAL THERAPY

As mentioned on the **consent to rehabilitation** page, it is likely that your care will involve direct bodily contact, hands on treatment, and/or close contact.

Because of this, and for the protection of you and others around you, please notify your provider if you have any conditions that can be transferred by blood, or any blood related disorders. Some of these may include, but are not limited to, the following:

Check YES or NO:

Are you taking blood thinners? YES _____ NO _____

Are you, or is there a chance that you could be, pregnant? YES _____ NO _____

Are you aware of any problems or have any concerns with your immune system? YES _____ NO _____

Do you have any known disease or infection that can be transmitted through bodily fluids? YES _____ NO _____

If you answered **YES** to any of the above, please discuss this with your therapist or provider.

MISSED APPOINTMENT POLICY

Our goal at Elevation is to provide you with the best care possible in order to help you achieve your goals and restore your pain free function.

Your attendance to therapy is a huge component of your recovery.

Please note our policies for missed appointments listed below:

1. **When possible, please give us a 48-hour notice of cancellation.**

2. **After 3 NO-SHOWS (i.e., you do not call to cancel your appointment) you must return to your primary care/referring provider for a new therapy order.**

3. **After 4 CANCELS within a 2 WEEK PERIOD, you must return to your primary care/referring provider for a new therapy order.**

Please sign below acknowledging that you have received and understand these policies.

_____ _____

Name **Date**