Welcome to our practice!

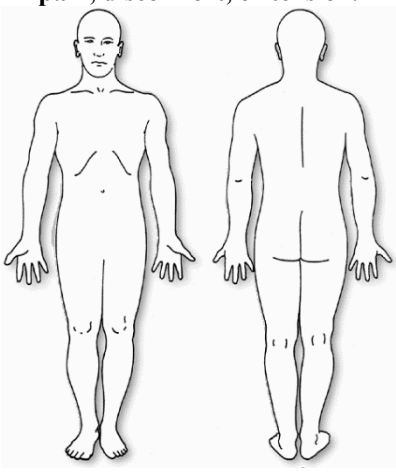
Name:	Last Name	First Name		Today's date:			
Address:							
City / State / ZIP:							
Phone #	MOBILE		HOME		WORK		
DOB:		Age:		Marital status:	M	S	W	D
Email:							
Occupation:		Employer:					
Emergency Contact	Name:		Phone:				
Primary Care Physician	Name:		Phone:				
Specialist Physician	Name:		Phone:				

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please mark the areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
☐	Massage	☐	Bodywork	☐	Physical Therapy	☐	Myofascial Release	☐	Chiropractic	☐	Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
☐	Diabetes	☐	Lung disease	☐	Weight change	☐	Varicose veins	☐	Neurological problems	☐	Pregnancy
☐	Rheumatic fever	☐	Osteoporosis	☐	Migraine headaches	☐	Epilepsy / seizures	☐	Stroke	☐	Blackouts
☐	Heart Murmur	☐	Malignancy	☐	Arthritis	☐	Broken bones (fracture	☐	Metal implants	☐	High blood pressure
☐	Circulatory problems	☐	Liver disease	☐	Heart disease / pacemaker	☐	Kidney disease	☐	**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	☐	Yes	☐	No	If "Yes" – How much?	
When did you quit?					If not, Would you like to quit?	

Do you leak urine, feces or gas?	☐ Yes	☐ No
Are you sexually active?	☐ Yes	☐ No
Do you have pain or lack of sensation with vaginal penetration or exams?	☐ Yes	☐ No
Is there a chance you may be pregnant at this time?	☐ Yes	☐ No

Do you engage in regular exercise?	☐ Yes	☐ No
What type and how often?		
Are you able to exercise now?	☐ Yes	☐ No

Do you have discomfort, shortness of breath, or pain with exercise?	☐ Yes	☐ No			
Please Describe:					
In general, your lifestyle is:	☐ 1 Active	☐ 2	☐ 3 Average	☐ 4	☐ 5 Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	☐ Yes	☐ No	Do you find it difficult to change positions in bed?		
Is your sleep restful?	☐ Yes	☐ No	How many times do you wake in the night?		
Do you find it difficult to lie down?	☐ Yes	☐ No	How long before you fall back to sleep?		

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	☐ Yes	☐ No
Do you have trouble putting on your shoes and socks?	☐ Yes	☐ No
Do you have difficulty climbing stairs?	☐ Yes	☐ No

Patient Goals
Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

OFFICE POLICIES & PROCEDURES

As a courtesy to others and our Therapists and to other patients trying to get scheduled, we require a 24-hour (or greater) notice for cancellations. This allows others on waiting lists to be seen. Only emergencies or illnesses are excusable. The full cost of the visit will be billed upon violation of this policy.

CONSENT TO COMMUNICATION

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check / circle and write all that you consent to):
  - o Email address: _____
  - o Text / phone / voicemail number:_____
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check / circle and write all that you consent to):
  - o Email address: _____
  - o Text / phone / voicemail number:_____

CONSENT TO TREATMENT

Fluid Physio is a hands-on Physical Therapy clinic. Thorough and highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of ultrasound, electrical stimulation, traction, deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, myofascial release, bone and soft tissue manipulation, as well as other treatment modalities may be used. Internal pelvic exams may be performed if symptoms and patient goals warrant it, and patient may defer or object to this at any given time. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Fluid Physio, LLC. I authorize Gianna Bigliani Cetkowski, PT, DPT, OCS, CSCS and the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.

_____ _____

Signature of patient/legal guardian Date

PAYMENT/BILLING POLICIES

You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. Payment is expected at time of service unless you have made other payment arrangements with us.

Out-of-Network Policy. (Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

Medicare Policy. If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our services do not meet the technical requirements for Medicare covered benefits, our services are *not* subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

- **Medicare as a Secondary Payer**. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare, unless we have agreed to accept assignment and await payment from your health insurance insurer (we do not accept assignment from Medicare). If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

_____ _____

Signature of Patient and/or Guardian **Date**

_____ _____

Signature of Provider Representative **Date**

Photograph & Video Release Form

Video recordings and photographs of our treatments help us get the word out about what we do and how we can help others. They also help us to teach others how to replicate our methods and better help their patients. With that said, please read below and let us know if you'd be okay with us recording and using any part of your treatment sessions.

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos
- for-profit endeavors

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Signature_____ Date_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____