



Patient Information			
Last Name	First Name	MI	Date of Birth
Occupation	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> O	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	
Address	City	State	Zip
Home Number	Mobile Number	Email	
Employer Name (Required for Worker's Comp Patients)	Employer's Phone Number	Employer's Contact Name	
Preferred Method of Contact: <input type="checkbox"/> Home Number <input type="checkbox"/> Mobile Number <input type="checkbox"/> Email			
Consent to Email Communication: I agree to receive email communication from Gold Rehab Services pertaining to appointment reminders, statements, and other account information, as well as clinic news and updates. _____ Initials			
Emergency Contact			
Primary Emergency Contact Name	Phone Number	Relation to Patient	
Secondary Emergency Contact Name	Phone Number	Relation to Patient	
Referral Information			
Referring Physician Name			
Referring Physician Phone	Referring Physician Fax		
Patient or Patient Guardian Name:			Date
Patient or Parent/Guardian Signature X			



Medical History Form

Name _____ Date Symptoms Began _____

In a few words, describe your symptoms _____

Are your symptoms related to an accident? ☐ Y ☐ N If yes, please describe the accident _____

Did your illness/injury require surgery? ☐ Y ☐ N If yes, please provide the date of surgery _____

Have you ever been diagnosed with any of the following conditions?
Check all that apply:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Syncope | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pregnancy _____ weeks |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker Implantation | <input type="checkbox"/> Cancer Type _____ |

Other conditions _____

Did you have any diagnostic testing for your current condition?

☐ X-rays ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Nerve Conduction Study ☐ MRI ☐ Other

Rate your pain intensity on a scale of 0-10. (0 being no pain)

Rate your current and prior level of function on a scale of 0% to 100%. (100% being you are fully functional)

Pain

Current ____/10

At best ____/10

At worst ____/10

Function

Current ____/Prior ____

What are your primary goals for physical therapy? _____

Patient or Parent/Guardian Signature

X

Date

Self-Pay Financial and Cancellation Policy

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Please note, all payments for self-pay appointments are due at time of service unless you have prepaid for a pack of appointments.

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a \$25.00 service charge for returned checks.

HSA/FSA

If you have an HSA (Health Spending Account) or FSA (Flex Spending Account), you may use it to pay for self-pay appointments. Please inform our office if you will be using an HSA or FSA account to pay for your services, so we can provide the necessary documentation to support the expenditure.

INSURANCE

When self-paying for appointments, our clinic will not submit your claims to your insurance. However, we are happy to provide you with an itemized statement, so you can submit it to your insurance. Please note, if you do plan to submit your charges to insurance, Gold Rehab Services is not responsible for submitting authorization, or other documentation to your insurance company.

PACKS OF APPOINTMENTS

Our clinic offers packs of appointments at a discounted rate. Please note, once an appointment pack is purchased the payment is not refundable. All visit of a pack must be used within the year they were purchased.

PRICING

30min Appointment \$100	45min Appointment \$150	60min Appointment \$200
30min 6-pack \$570	45min 6-pack \$870	60min 6-pack \$1170
30min 12-pack \$1080	45min 12-pack \$1680	60min 12-pack \$2280

CANCELLATION AND NO-SHOW POLICY

If you are unable to keep your scheduled appointment, please provide 24-hour notice. Any late cancellations will incur a \$50.00 fee. Failure to show for an appointment will result in a \$75 no-show fee. As a reminder, cancellation and no-show fees are not covered by insurance.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Patient Guardian Name:

Date

Patient or Parent/Guardian Signature X

Consent to Physical Therapy Evaluation and Treatment

Physical Therapy is a patient care service that is provided to manage and treat a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to prevent and treat disease, injury, and disability through examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization of joints and soft tissues, manipulation, exercises, patient education, and physical agents to help the patient reach their greatest potential within their capabilities, to accelerate convalescence, and to reduce the length of functional recovery. All procedures will be thoroughly explained to you as needed and requested before you are asked to perform or participate in them.

Response to physical therapy intervention varies from person to person, hence it is not possible to accurately predict your response to a specific procedure, exercise protocol, or modality. **Gold Rehab Services** does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort, pain, or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care.

Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices of **Gold Rehab Services**. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of **Gold Rehab Services** health care operations. The Notice of Privacy Practices also describes my rights and **Gold Rehab Services**' duties with respect to my protected health information. The Notice of Privacy Practices is also available at the clinic location and on the **Gold Rehab Services** website at www.goldrehabservices.com. **Gold Rehab Services** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the **Gold Rehab Services** website.

By my signature below, I certify that I have read, understand, and fully agree to the statements in this section and sign below freely and voluntarily.

Patient or Patient Guardian Name:

Date

Patient or Parent/Guardian Signature X