MSPT
MID-SOUTH PHYSICAL THERAPY

Patient History Form

Name:_____ **Date:**_____

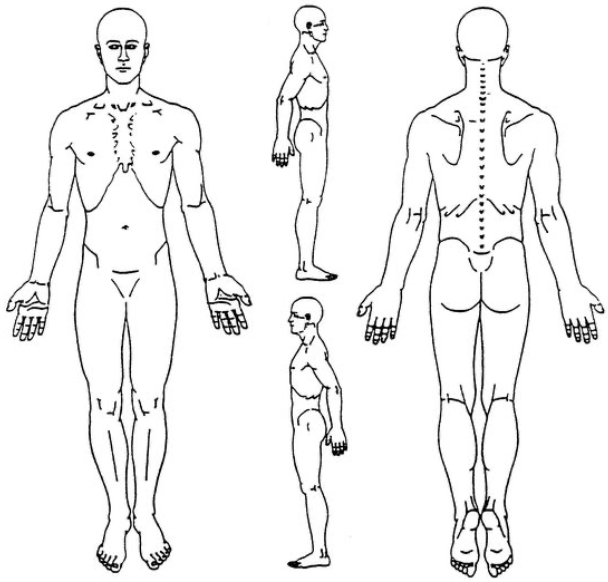
D.O.B:_____ **SSN:**_____ **Gender:**_____

Current Address:_____

E-Mail Address:_____ **MD appt:**_____

Lawsuit: Y/N:_____ **Injury:**_____

Current Symptoms (Please Mark On Figure Area Where You Are Currently Experiencing Discomfort Using Key)
Dull/Aching: DDD **Burning:** XXX **Numbness:** === **Stabbing:** ///
Pins/Needles: ••• **Cramp:** CCC **Weakness:** WWW **Sharp:** SSS



Pain Level (Mark on Scale) : 0 I----------2----------4----------6----------8----------I 10

History of Falls: Y/N _____

Are you experiencing any Dizziness, Blurred Vision or Headaches? _____

Goal for Physical Therapy: _____

MSPT Witness _____ Print _____ Date_____

MSPT
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Patient History Form Continued

Do You or Have You Had Any of the Following?

[ ] Diabetes	**[ ] Cancer**	**[ ] Chest Pain/Angina**
[ ] Osteoporosis/Osteopenia	**[ ] High Blood Pressure**	**[ ] Asthma/COPD**
[ ] Heart Disease	**[ ] Dizziness**	**[ ] Heart Attack**
[ ] Seizures/Epilepsy	**[ ] Pacemaker**	**[ ] Stroke/TIA**
[ ] Kidney Problems	**[ ] Fracture**	**[ ] Bone/Joint Surgery**
[ ] Unexplained Weight Loss	**[ ] Rheumatoid Arthritis**	**[ ] Fibromyalgia**
[ ] Lupus	**[ ] Traumatic Brain Injury**	**[ ] Spinal Cord Injury**

Have You Had Any Imaging Studies Performed For Your Condition? Y/N _____

If you answered yes, what imaging studies were performed (X-Ray, MRI, CT) and what were the results?_____

Please List Any Applicable Bone/Joint Surgeries and Dates:

_____

_____

Please List Any Medications That You Are Currently Taking: (If you have a list please provide instead):

_____

_____

Emergency Contact Information:

Person to contact in case of emergency: _____

Relationship:_____ Phone Number:_____

Information Release and Payment Request:

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request. Additionally, I request that authorized benefits be made on my behalf.

Signature and Date:_____

MSPT Witness _____ Print _____ Date_____

MSPT
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Informed Consent
Grade V Spinal Mobilization/Dry Needling and Treatment Authorization and Release

Please read this entire document before signing, it is important that you understand the information contained in this document. Please ask questions if anything is unclear prior to signing. I have had the opportunity to discuss with MSPT the nature and purpose included but not limited to Grade V Spinal Mobilization/Dry Needling and other procedures. I understand that Grade V Mobilization requires a high velocity low amplitude skilled impulse to the treatment areas if deemed appropriate.

I also understand that, as with any healthcare procedure, there are certain complications which may arise during spinal mobilization and therapy. While these complications are extremely rare they include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of mobilization of the neck have been associated with injuries to the arteries in the neck leading to/or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Every reasonable effort will be made during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As part of the analysis, examination, and treatment you are consenting to the follow procedures: (Please initial beside each).

___ Spinal Mobilization	___ Dry Needling	___ Class 4 Laser Therapy	___ Palpation
___ ROM Testing	___ Ortho Testing	___ Muscle Testing	___ Cupping
___ Thera-gun	___ Rock Floss	___ Rock Tape	___ IASTM/FRAMS
___ Tempering	___ Vitals	___ Neuro Testing	___ Other: _____

I hereby request and consent to the performance of spinal mobilization and other therapeutic procedures, including various modes of therapy modalities on myself by the licensed Doctor of Physical Therapy employed by MSPT, Inc. I have also read or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment by MSPT.

Patient Signature _____ Print_____ Date_____

MSPT Witness _____ Print _____ Date_____

MSPT
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Acknowledgement of Financial Liability

I fully understand that I am responsible for payment of all charges that are incurred for my treatment. I understand that MSPT, Inc will bill my insurance or appropriate agency for me if I so desire and indicate. Please be aware that any parent/guardian is legally responsible for the payment of all services rendered. It is very important to remember that your insurance program is a contract between YOU, YOUR EMPLOYER, and INSURANCE COMPANY. We file your insurance as a courtesy to you. You NOT the insurance company are responsible to us for all of the charges for services rendered.

Signature and Date:_____

MSPT No- Show and Late Arrival Policy

We schedule our appointments to allow each patient to receive the proper amount of time to be seen. It is important to us you keep your scheduled appointment and arrive on time. If you are over 10 minutes late you will NOT be able to be seen that day. As a courtesy to you, we will print you appointment reminders for you.
If your schedule changes and you will be later than 10 minutes or not be able to attend, please contact us to reschedule you. Ideally, we ask you give 24 hours notice if possible to fill the rescheduled appointment. We reserve the right to charge $25 as a "no show" charge, this is not reimbursable by your insurance. After 3 consecutive no-shows, our practice may decide to terminate its relationship with you.

Signature and Date:_____

Privacy Policy

We understand that your medical information is personal to you and we are committed to protecting this information. As our patient we create both paper and electronic medical records about your health, and our care to you. In order to comply with Healthcare Privacy requirements, we require documentation to show you are aware of our commitment to protecting your information and privacy. You have the right to review this notice prior to signing it.

MSPT Witness _____ Print _____ Date_____

MSPT
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Patient Information Acknowledgement

I have fully read and fully understand the MSPT notice of Patient Information Practices. I understand that MSPT may use or disclose my personal health information for the purposes of carrying our treatment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to amend or restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MSPT will consider requests for amendment and/or restriction on a case by case basis, but does not have to agree to these requests.

I hereby consent to the use and disclosure of my personal health information for purposes noted in MSPT Notice of Patient Information Practices. I understand that I retain the right to revoke the consent by notifying the practice in writing at any time.

Signature:_____ Print:_____ Date:_____

Release of Records

We understand that you may at times need persons other than yourself to have access to your medical or billing information. Please indicate below the name of the person(s) you authorize to have access.

Name:_____ Relation:_____ Number:_____

Name:_____ Relation:_____ Number:_____

Name:_____ Relation:_____ Number:_____

Name:_____ Relation:_____ Number:_____

Signature (if authorizing release of records) and Date: _____

Effective May 1, 2009: Healthcare providers, including physical therapy facilities, must comply with the FTC "Red Flag" rule, which requires creditors to establish a program to prevent identity theft in their practices. This requirement is part of the FTC's implementation of the Fair and Accurate Credit Transactions Act of 2003. The FTC recommends a compliance program for "low risk practices" that involves checking photo identification. Accordingly, MSPT will now require positive identification of all patients identity at the outset of any treatment provided in this facility.

MSPT Witness _____ Print _____ Date_____