PhysioPoint
THERAPY & WELLNESS

1841 East Summit Street
Crown Point, IN 46307

219-801-7777

Acknowledgement of Receipt of Notice of Privacy Practices
HIPAA

By my signature below, I acknowledge the following:(check which applies)

I have received PhysioPoint Therapy and Wellness's Notice of Privacy Practices

OR

I have been offered and declined to receive the PhysioPoint Therapy and Wellness's Notice of Privacy Practices.

I would like the following people to have access to my medical records at PhysioPoint Therapy.

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____

____

Signed:____________________________________

Patient Printed Name:____________________________________Date:________

Relationship to patient if not signed by patient: ____________________________________

PhysioPoint
THERAPY & WELLNESS

GENERAL CONDITIONS FOR PARTICIPATION

Please check each item and sign below:

□ **AUTHORIZATION FOR THERAPY SERVICES** I understand I will be informed of the procedure and/or treatments considered necessary for the client whose name appears below and that the treatment and procedures will be performed by a licensed physical therapist and/or associate. I hereby authorize such treatment and procedures. I understand the PhysioPoint Therapy & Wellness provides educational training for healthcare professions and students may assist in or observe my care.

INSURANCE VERIFICATION COURTESY We will verify your insurance benefits as a courtesy, however it is not a guarantee of payment. Ultimately it is your obligation to know your benefits. You will be responsible for charges that your insurance does not pay.

CANCELLATION POLICY Please give us a **phone call** AT LEAST 24 hours prior to your scheduled visit if you need to cancel an appointment so that someone else can take your spot. Late cancellation or not showing for your scheduled visit will result in a **$50.00 CANCELLATION FEE**.

****Text messages will not be accepted for cancellations. Please call 219-801-7777.**

*****No visitor under the age of 14 is allowed to accompany the client in order to provide a safe, healing environment.**

______________________________________ __________________

PATIENT/LEGAL GUARDIAN/GUARANTOR DATE

OPTIONAL:

PARENTAL PERMISSION I give PhysioPoint Therapy & Wellness permission to treat my child who is under the age of 18 without my presence.

AUTHORIZATION TO BE PHOTOGRAPHED PhysioPoint Therapy and Wellness has my permission to take my photo in order to measure before and after results and for teaching purposes.

DO NOT RESUSCITATE I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

Are you interested in a free health coaching consultation? Yes / No

Are you interested in any of the following?

Smoking Cessation Dietary Guidelines After Care Exercise Pilates Vitamins/Supplements

YOUR MEDICAL HISTORY

How can we help you?____

____Date of Injury____/___/_____

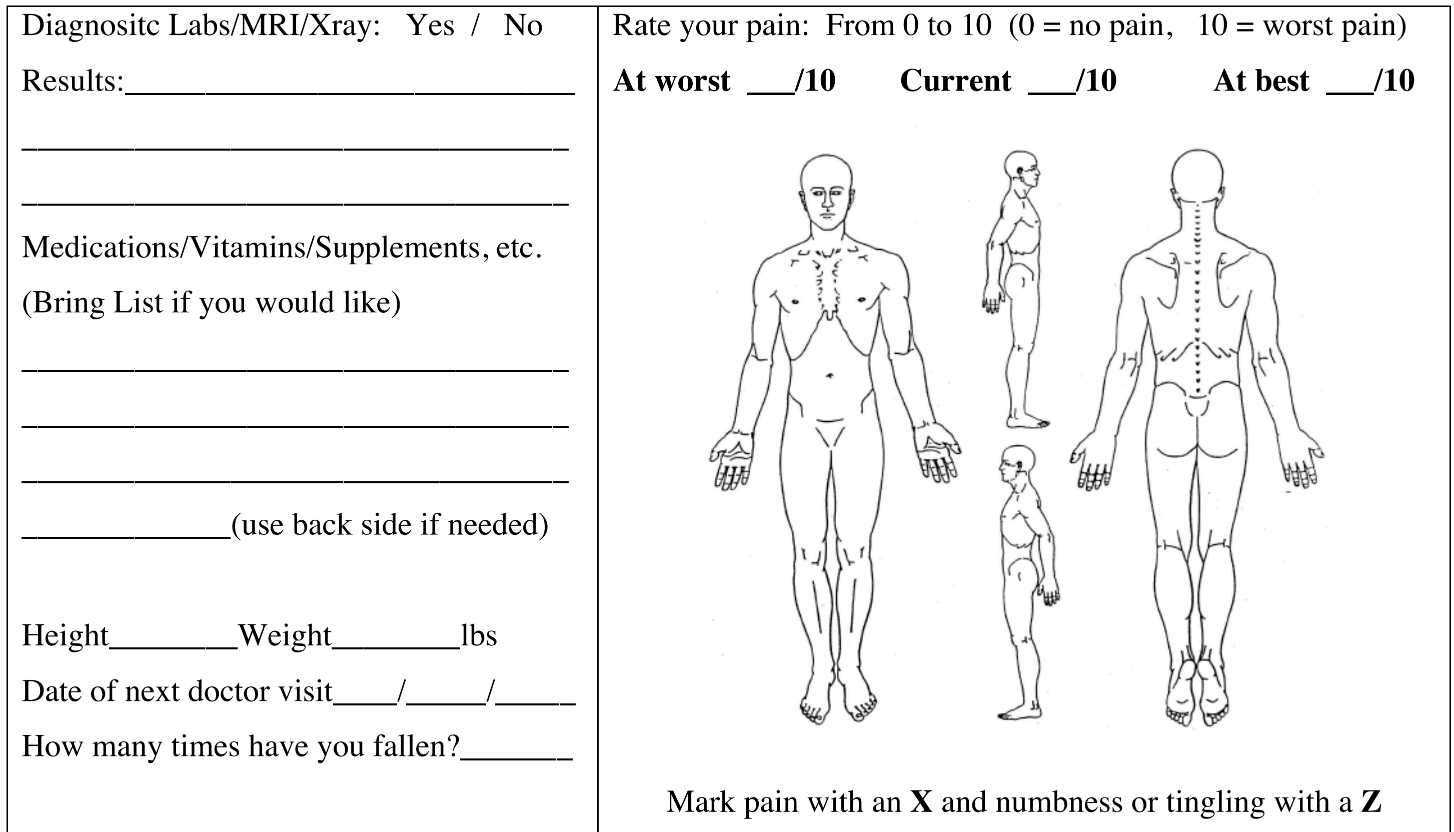
Describe your Pain (circle)		What makes it worse?		What makes it Better	
Burning	Constant	Sitting	Bending	Bending	Lying
Sharp	Intermittent	Standing	Voiding	Sitting	AM
Dull/Achy	Worse in AM	Walking	Lying Down	Turning	As the day progresses
Throbbing	Worse in PM	Up Stairs	Cough/Sneeze	Rising	PM
Shooting	Wakes me up	Down Stairs	Sleeping	Standing	When Still
Numbness/Tingling		Sit to Stand		Walking	On the move
Other:______________________		Other:______________________		Other:______________________	

Conditions: Osteoathritis Cardiovascular Disease Diabetes type 1 Diabetes type 2 Allergies
Cancer Car Accident Current Infection Immunosuppression Fracture Osteoporosis
Lung Asthma Fibromyalgia High Blood Pressure Rhuematologic Thyroid
Dizziness/Vertigo Psychological Skin Gastrointestinal

Any Other Conditions____

____

Past Surgeries:____



Diagnositc Labs/MRI/Xray: Yes / No

Results:____________________________

____

____

Medications/Vitamins/Supplements, etc.

(Bring List if you would like)

____

____

____

_____________(use back side if needed)

Height________Weight________lbs

Date of next doctor visit____/_____/_____

How many times have you fallen?_______

Rate your pain: From 0 to 10 (0 = no pain, 10 = worst pain)

At worst ___/10 **Current ___/10** **At best ___/10**

Mark pain with an **X** and numbness or tingling with a **Z**