Premier
PHYSICAL THERAPY

5008 W. 92nd Ave
Westminster, CO 80031
(303) 412-7035

PATIENT INFORMATION (PLEASE PRINT CLEARLY)				
First Name:	Last Name:			M.I. :
Birth Date: / /	Age:	☐ Male ☐ Female		
Address:	City:	State:	Zip:	
Cell Phone: ( )	Home Phone: ( )			
Email Appointment Reminder: ☐ YES ☐ NO				
Email Address:				
I Chose This Clinic Because:				

WORK INFORMATION		
Employer:	Work Phone: ( )	Ext.:
Occupation:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

REFERRING DR. / FACILITY	
Referring Dr.:	Regular Dr.:

INSURANCE INFORMATION	
Name of Primary Insurance:	Name of Secondary Insurance:

IN CASE OF EMERGENCY	
Name of Emergency Contact:	Relationship to Patient:
Home Phone: ( )	Work Phone: ( )

AUTO OR WORK INJURY CLAIM (If you have an Auto or W/C claim for THIS Injury)			
Insurance Name: ☐ Auto:	☐ Workers Comp:		
Adjuster/Claim Manager:	Phone: ( )		Ext.:
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION (If you have an Attorney for THIS Injury)			
Name:	Law Firm:	Phone: ( )	
Address:	City:	State:	Zip:

I authorize my insurance benefits be paid directly to Premier Physical Therapy. I understand that I am financially responsible for my balance. I also authorize Premier Physical Therapy to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE **DATE**

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Name: _____

Date: _____

PAST MEDICAL HISTORY

BLOOD PRESSURE	YES	NO
High Blood Pressure		
Low Blood Pressure		

HEART DISEASE	YES	NO
Heart Attack		
Stroke		
Pacemaker		

LUNGS	YES	NO
Asthma		
Emphysema		
Tobacco use?		
Are you pregnant?		

OTHER CONDITIONS	YES	NO
Muscular Dystrophy		
Multiple Sclerosis		
Epilepsy (Seizures)		
Cancer		
Fibromyalgia		
Diabetes		
Hearing Loss		
Poor Eyesight		
Polio		
Joint Replacement		
Osteoporosis		
Recent Steroid Injection?		

Have you had any falls in the last year, if so how many? _____

Please list all surgeries in the last two years. _____

_____

Have you had any physical therapy within the last year? ☐ YES ☐ NO

What are your goals for physical therapy? _____

If this is an Auto or W/C claim, please list body part affected and date of accident/injury. ☐ N/A

_____

List all current medications you are taking and include name, dosage, frequency and method or attach a list.

_____

_____

_____

_____

_____

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3501 Highland Pl.
Westminster, CO 80031
(303) 951-8350

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, **Premier Physical Therapy,** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this practice.

We are providing you with a copy of our Notice of Privacy Practices, of which we request you review prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should made in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected. This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

CANCELLATION AND NO-SHOW POLICY

You are coming to physical therapy to remedy the condition that is affecting you; therefore, it is necessary that you attend all of your scheduled appointments.

All missed appointments MUST be made up within the same week so you may fully recover.

Premier Physical Therapy requires 24-hour notice for any cancellations. If you no-show or do not give 24 hours of notice 2 times, you will be charged a $15.00 fee, and your therapist has the right to discharge you from our service. You will be required to follow up with your physician to obtain a new physical therapy referral if you wish to resume treatment at our clinic. **We also reserve the right to reschedule your appointment if you are more than 10 minutes late for your scheduled appointment.**

PATIENT NAME (PRINT)	SIGNATURE	DATE

Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provide by Premier Physical Therapy.

_____

Signature

_____

Print name Date

COVID-19 WAIVER

I understand and acknowledge:

(1) The virus known as COVID-19 is currently active in the community;

(2) COVID-19 is highly contagious and easily spread through interpersonal contact, even when the carriers of COVID-19 are asymptomatic;

(3) It is impossible for any business, including Premier Physical Therapy LLC, to guarantee that any customer or client visiting the business's premises will not contract COVID-19;

(4) Premier Physical Therapy LLC provides rehabilitation, physical therapy, and other services that entail close personal contact;

(5) Such close personal contact could, however unlikely, result in my contracting COVID-19; and

(6) Understanding these risks, I still wish to receive services from Premier Physical Therapy LLC.

THEREFORE, and as a condition of my receiving services at Premier Physical Therapy LLC, I hereby release and waive any claim that I might ever have against Premier Physical Therapy LLC (including its owners, its employees, and its contractors) that arises from or relates to my potential or actual contraction of COVID-19.

I further agree not to sue or bring any legal action against Premier Physical Therapy LLC (including its owners, its employees, and its contractors) arising from or related to my potential or actual contraction of COVID-19. In the event that I bring such action anyway and fail to prevail in that action, I agree to pay the reasonable attorney fees and costs that Premier Physical Therapy LLC (including its owners, its employees, and its contractors) incurs defending itself.

_____ _____

Signature Date

_____

Print Name
(State if Signing on Behalf of Patient)