YUJ
PHYSICAL THERAPY

Patient Intake Form

Patient Information

Last Name	First Name	Middle / Middle Initials

Street Address	City	State	Zip

Sex ( ) Male ( ) Female	SSN #	DOB (MM/DD/YYYY)

Home Phone OK to call?	Cell Phone OK to call?	Email Address

Referring Physician	Address	Phone

Emergency Contact Name	Relation	Phone

Is the patient currently receiving (or has recently received) physical therapy?

Agency Name	Agency Phone	Date of Discharge (MM/DD/YYYY)

Diagnosis	Date of Injury (MM/DD/YYYY)

Insurance Information

Insurance Company	Phone Number

Primary Subscriber Name	Primary Subscriber DOB (MM/DD/YYYY)	Relation

Member ID#	Group ID	Group Name

Consent to Treatment

- I authorize Yuj Physical Therapy to provide treatment to me. I understand methods of treatment may include, but are not limited to: Therapeutic Exercises, Manual Therapy and other modalities as deemed appropriate by my Physical Therapist per standard of care
- I understand that I am responsible for all charges incurred regardless of insurance or 3rd party liability
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account
- I authorize Yuj Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency / attorney for collections or legal action
- I authorize my insurance company or any other concerned 3rd party to make payment directly to Yuj Physical Therapy
- For patients under 18 years of age; the parent, relative or person *escorting* the patient is responsible for any payments due at the time of the service.

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete

Signature _____ Printed Name _____ Date _____

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Medical History Intake

Patient History

Last Name	First Name	Middle / Middle Initials

Are you presently working?	Rate your pain (0=No Pain, 10 = Worst you can imagine)

Do you have or had any of the following?

Pacemaker	Yes	No	Unusual Headache	Yes	No
Chest Pain/Angina	Yes	No	Osteoporosis Hernia	Yes	No
Heart Disease/Attack	Yes	No	Seizures	Yes	No
High Blood Pressure Cancer/	Yes	No	Metal Implants	Yes	No
Tumor	Yes	No	Dizziness/Fainting	Yes	No
Kidney Problems	Yes	No	Fracture	Yes	No
Stroke	Yes	No	Surgeries	Yes	No
Bowel/Bladder Abnormalities	Yes	No	Skin Abnormalities	Yes	No
Pregnancy	Yes	No	Nausea/Vomiting	Yes	No
Asthma/Breathing Difficulties	Yes	No	Ringing in ears	Yes	No
Liver/Gallbladder Problems	Yes	No	Loss in Balance	Yes	No
Hypoglycemia /Diabetes	Yes	No	Difficulty walking	Yes	No
Osteoarthritis/Rheumatoid	Yes	No	Smoking	Yes	No
Rheumatic Arthritis Sensitivity	Yes	No			

Other _____

Please list all current medications (include ALL known prescriptions, OTCs, herbals, vitamins/mineral/dietary/ nutritional supplements)

Medication	Dosage	Frequency	Method	Medication	Dosage	Frequency	Method

Please list recent surgeries with dates as applicable	Do you have known drug allergies? Please out

I acknowledge that all the information that I have supplied on these forms is true and complete

Signature _____ Date _____

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Consent to Treat

Informed Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Yuj Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. 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 very important to communicate with you treating physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or 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 risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

I understand the above information and authorize the release of my medical information to appropriate third parties.

Signature _____ Printed Name _____ Date _____

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Notice of Privacy Practices

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Signature _____ Printed Name _____ Date _____

I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as indicated:
Date:_____Initials:_____:Reason:_____