CONSENT FOR TREATMENT

I hereby agree and give my consent for Dorset Physio Physical Therapy PLC (DBA Stratton Physio) to provide physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Patient Signature: _____ Date: _____

Parental Consent for Treatment As parent and/or legal guardian of: _____
-I authorize Dorset Physio to provide treatment while I am not present.
-I am aware a chaperone must be present if treatment is provided to sensitive areas.

Parent/Guardian Signature:_____Date:_____

PAYMENT POLICY- *Please Read Carefully*

_____ (initial) **Assignment of Benefits**:
I understand and authorize the release of medical information to file health insurance claims for me by Dorset Physio. I authorize Dorset Physio to bill my insurance company directly for the covered portion of the charges. I also authorize my insurance provide(s) to pay Dorset Physio Outpatient Physical Therapy directly.

_____ (initial) **In Network Insurance Benefits**:
Dorset Physio Outpatient Physical Therapy is In-Network with MVP, Aetna, Blue Cross Blue Shield VT, Medicare (with a Supplement), and Vermont Medicaid.

- **It is your responsibility to know your benefit information and you are ultimately financially responsible for all services rendered to you.**
- Collection of copays are at the time of service. Please note that what we collect in the office may only be a portion of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim.
- If you have further financial obligations than what we collected in the office, you will receive a statement from our office to be paid in full within 30 days.

_____ (initial) **Out of Network Insurance Benefits**:
If we are out-of-network with your insurance provider (if your plan is not listed above), you are responsible for payment at the time of service as a cash rate. We provide a superbill to you to submit to your insurance company for reimbursement upon request.

_____ (initial): **Card on File Policy**:
We require that a credit card be on file for unpaid invoices incurred from treatment or fees incurred from our payment policy. Your card will automatically be charged if you do not pay your invoice within 30 days upon receiving your bill via email, mail, or in person. A $50 fee will automatically be charged if you do not show or cancel less than 24 hours before your scheduled appointment.

By signing below I agree to pay my deductible, co-insurance, co-payment, and/or any charges not reimbursed by my insurance carrier. I have read and understand the above information and I understand my responsibility for the payment of my account.

Patient Signature: _____ Printed Name: _____
If Patient is a Minor: Parent/Guardian Signature _____ Date: _____

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed.
Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.
Your right to an Accounting of Disclosures: You have the right to request in writing, a list of accounting or any disclosures of your medical information we have made, except for uses and disclosures for treatment. payment, and health care operations, as previously described.
Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. We are not required to agree to your request.
Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.
Your Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice at any time.
Changes to this Notice: We reserve the right to change this notice, and will post the current notice in our facility.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Security of the Department of Health and Human Services.
Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about
you for the reasons covered by your written authorization- You understand that we are unable to take back any disclosures we have already made with your permission. and that we are required to retain our records of the care that we provided to you.

Notice of Privacy Practices for Protected Health Information Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of l996 (HIPAA) was legislated. Effective May 18, 2020. As part of this law, Dorset Physio Physical Therapy is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronica|ly or on paper.

Acknowledgment (Receive HIPAA Paper Copy)

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Patient Signature: _____ Printed Name: _____
If Patient is a Minor: Parent/Guardian Signature _____ Date: _____

SESSION RECORDING NOTICE AND CONSENT

For the purpose of clinical documentation, your therapy session may be audio recorded. The recording is used to help your clinician accurately document your visit and may be transcribed to support completion of your medical record. Recordings and any related transcripts are stored securely as part of your health record and are accessible only to authorized members of your care team. All documentation remains under the review and control of your clinician. Recording is limited to your therapy session and is not used for marketing, advertising, or any non-clinical purpose.You may ask questions or request that recording not be used for your session. Declining recording will not affect your care or treatment.

By signing this document I consent to have my session recorded.
Patient Signature: _____ Date: _____
If Patient is a Minor: Parent/Guardian Signature _____

____ Initial to Decline Recording

NO SHOW / LATE CANCELLATION POLICY

This policy has been created in order to provide the highest level Physical Therapy Service to all of our patients. By providing us a notice of cancellation, we may be able to accommodate other patients in need of our services.

- Patients must call at least 24 hours prior to their scheduled appointment tame, when they knowingly are unable to make their appointment. Cancellations within 24 hours of appointment will be considered a late cancellation.
- Less than 24 hours notice for cancellations are appropriate for situations such as illness or poor weather conditions. The safety of our patients and staff remains our highest priority.
- We do understand that emergencies and unexpected situations arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the clinic director and/or therapist at their discretion.
- **After one (1) No-Show/No-Call:** the patient will need to contact the PT clinic to confirm that they are able to attend their next upcoming appointment. If a confirmation call is not received, any follow up appointments will be removed from the schedule.
- **After two (2) No-Show/No-Calls**: the patient will be discharged from treatment. At this time, a letter will be sent to your physician and all future appointments will be removed from the schedule.
- **After three (3) Late Cancellations, No Shows or Combination Thereof**: the patient will be discharged from treatment. At this time, a letter will be sent to your physician and all future appointments will be removed from the schedule. We will assist you in finding care at another facility that will meet your needs.
- Appointment reminders are provided via the patient's choice of a reminder call, text and/or email (unless they choose not to be called) Patients will always be provided a copy of their scheduled appointments and can be found on your patient portal.

By signing this document I understand and agree to adhere to Dorset Physio Outpatient Physical Therapy's No Show/Cancellation Policy.

Patient Signature: _____ Printed Name: _____
If Patient is a Minor: Parent/Guardian Signature _____ Date: _____

PATIENT HEALTH HISTORY PAGE 1

Name_____ **Date of Birth:** _____ **Today's Date:**_____

Gender (circle): M F Other:_____ **Preferred Pronoun (circle):** She/her/hers He/him/his They/them/theirs

Referring Provider *(if applicable)*: _____ **Primary Care Provider:**_____

Emergency Contact Name:_____ **Phone Number:** _____

Have you ever been to PT? ***(circle)*** **YES NO** If so, how many times this year? _____
Are you currently or have received any HOME HEALTH CARE? YES NO End Date: _____

Current Complaints/Concerns (why you are here for physical therapy):_____
_____

Date of Onset of Symptoms: _____ **Date of Surgery(if applicable):** _____

Have you had any imaging for your condition? ▢MRI ▢ X-Ray ▢CT Scan Where:_____

ALLERGIES: _____ **Are you allergic to LATEX or ADHESIVES ? Y N** _____

Please list all Medications, Vitamins/Supplements *(if you have a printed list we can photocopy for you):*
_____

Do you use any alcohol, drugs, smoke or vape ? Y N What and how frequent?_____

MEDICAL HISTORY (Please explain in detail below as needed)

**Reminder: all of your medical history is important to us of even if you do not think it pertains to why you are here*

- ☐ **Arthritis** _____
- ☐ **Osteoporosis/Osteopenia** (circle)
- ☐ **Heart Problems**_____
- ☐ **Kidney/Liver Disease**_____
- ☐ **High Blood Pressure**
- ☐ **Diabetes**_____
- ☐ **Cancer**_____
- ☐ **Fractures**_____
- ☐ **Fibromyalgia/Chronic Pain**
- ☐ **Anxiety/Depression**_____
- ☐ **ADHD/Autism**_____
- ☐ **Implant(s): Pacemaker/DBS/Etc:** _____
- ☐ **Asthma/Lung Problems**_____
- ☐ **Headaches/Migraines**_____
- ☐ **Neurological Disorder(s)**_____
- ☐ **Head Injuries/Concussions**_____
- ☐ **Parkinson's/Parkinsonism**_____
- ☐ **Vision/Hearing/Memory Loss**_____
- ☐ **HIV/AIDS/Hepatitis/Blood Disorders** _____
- ☐ **Currently Pregnant or Breast Feeding? (circle) Yes No** _____
- ☐ **Other:** _____

List Any Past or Upcoming Surgeries: _____

HEALTH HISTORY PAGE 2

PAIN DIAGRAM: Please draw on the bodies below the right the locations of your pain, and indicate the nature of your pain (best, worst, time of day, and if it is intermittent or constant). *0=NO PAIN 10=EXCRUCIATING PAIN*

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

BEST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 0 1 2 3 4 5 6 7 8 9 10

IS YOUR PAIN (circle one):

INTERMITTENT OR CONSTANT

TIME OF DAY PAIN IS BEST (circle one):

MORNING AFTERNOON NIGHT

TIME OF DAY PAIN IS WORSE (circle one):

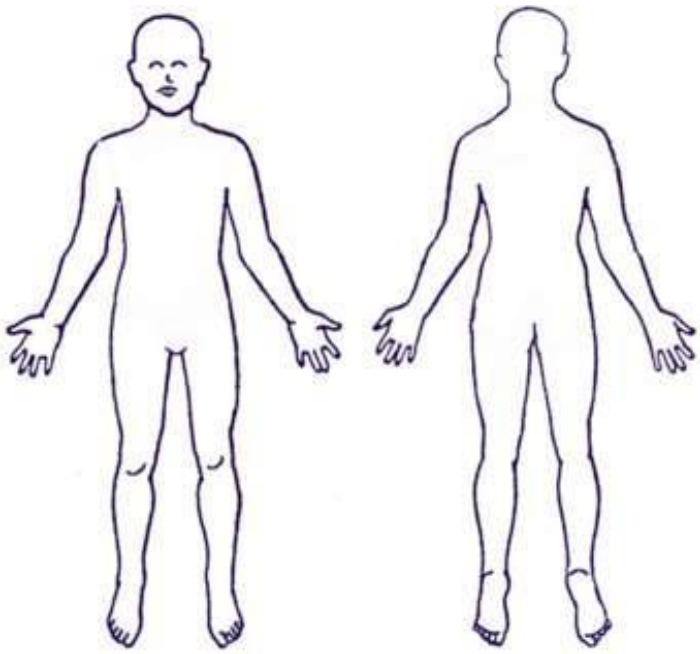
MORNING AFTERNOON NIGHT

WHAT MAKES YOUR PAIN BETTER?

_____

WHAT MAKES YOUR PAIN WORSE?

_____



What goals would you like to achieve by coming to physical therapy:

_____

MEDICARE PATIENTS OR IF YOU ARE OVER 65 (required):

IF YOU HAVE SUSTAINED A FALL PLEASE ANSWER THESE QUESTIONS:

1.Are you afraid to fall? *(circle one)* YES NO

2.Have you had any falls in the past 6 months?*(circle one)* YES NO How many:_____

2a.If YES, Any fall(s) that resulted in injury? *(circle one)* YES NO Describe:_____

3.Do you use any Assistive Devices/Equipment (circle all that apply): Brace/Splint Cane Walker Crutches Walking Poles Wheelchair Lift Chair Shower Chair Bedside Commode

All patients sign below that the information above is accurate to the best of my knowledge.

Patient Signature: _____ Printed Name: _____

If Patient is a Minor: Parent/Guardian Signature _____ Date: _____