ON THE GO PHYSIO

PATIENT INFORMATION:

Name: ____________________________________

DOB: __________________ Sex: M F Phone number: ________________________

Email address: ____

Address: ____

City: _____________________ State: _______ Zip Code: _______________________

Employer name: ____

Occupation: ____

Emergency Contact: ______________________________ Phone: __________________

Relationship to patient: ____

How did you hear about On The Go Physio: _____________________________________

Referring physician: ____

Primary care physician: ____

QUESTIONAIRE:

Reason for PT (i.e. which part of body): _______________________________________

Describe your issue in detail, including when it started and whether it was due to an injury:

____

____

____

Previous history of this issue? If yes, please describe: _____________________________

____

Have you had any scans or diagnostic tests (i.e. x-ray, MRI): ________________________

____

Have you had any prior treatments for this condition (PT, chiropractic, injections, massage):

____

ON THE GO PHYSIO

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT APPLY. YOU MAY ADD ADDITIONAL COMMENTS AS NEEDED IN THE SPACE BETWEEN SECTIONS

General/Constitutional:

Change in appetite	Chills	Fatigue
Fever	Headache	Lightheadedness
Sleep disturbance	Weight gain	Weight loss
Night sweats		

____

____

____

Allergy/Immunology:

Cough	Itching	Rash

____

Ophthalmologic:

Blurred vision

____

ENT:

Difficulty swallowing	Sore throat

____

Endocrine:

Cold intolerance	Difficulty sleeping	Dizziness
Excessive thirst	Frequent urination	

____

Respiratory and Cardiovascular:

Chest pain	Palpitations	Irregular heartbeat
Shortness of breath		

____

Gastrointestinal :

Decreased appetite

____

Hematology:

Easy bruising | Prolonged bleeding

____

Musculoskeletal:

Painful joints | Swollen joints | Leg cramps
Joint stiffness | Sciatica

____

Peripheral/Vascular:

Ulceration of feet

____

Skin:

Skin cancer

____

Neurologic:

Low back pain | Memory loss | Seizures
Tingling/Numbness | Balance difficulty | Gait abnormality

____

Psychiatric:

Suicidal thoughts | Eating disorder

____

Medical History: (circle one)

Pregnant, or possibly pregnant: Y N

History of cortisone or steroid injections: Y N

General health rated as: Excellent Good Fair Poor

Family History:

Father: Living Deceased

Medical conditions:____

Mother: Living Deceased

Medical conditions: ____

Social History:

Marital Status: Single Married Divorced Widowed

Alcohol Consumption: # of drinks per week _______

Smoker: Y N

Chews Tobacco: Y N

Drug Use in Past 12 Months: Y N

Physical Activity Level:

- Inactive – sedentary lifestyle
- Moderate – household activities, gardening, walking
- Active – moderate exercise 1-3x/wk
- Vigorous - regular (3-5x/week) vigorous exercise and/or sports activity.

Activities: ____

Medications: ____

____

Height: __________ Weight: __________

Surgical History:

Surgery: ____ Date: _________

Surgery: ____ Date: _________

Surgery: ____ Date: _________

Surgery: ____ Date: _________

Surgery: ____ Date: _________

Surgery: ____ Date: _________

Hospitalization History:

Reason: ____ Date: _________

Reason: ____ Date: _________

Reason: ____ Date: _________

Reason: ____ Date: _________

Reason: ____ Date: _________

Allergies:

List all allergies you may have, including those to medications

____

____

____

Signature: _____________________________________ Date: _________________

ON THE GO PHYSIO

THERAPY CONSENT FORM

Consent for Evaluation
By signing below, the patient gives the therapist permission to evaluate their condition and determine a plan of care based on the referring physician's order/diagnosis.

It is up to the patient or caretaker to inform the therapist about any health problems or allergies the patient may have. The patient or caretaker must also tell the therapist about drugs or medications being taken as well as any medical conditions and/or surgeries.

During an evaluation the patient will undergo a physical exam, including the health history and certain testing that may include: posture, movement, flexibility, muscle testing, joint motion, memory, as well as overall physical performance.

Consent for Treatment
By signing below, the patient gives the therapist permission for treatment. It is a patient's right to accept or refuse any treatment offered. There are no guarantees made regarding the results that may be obtained from treatment and benefits of treatment may be realized gradually overtime.

Please discuss any questions or problems with the therapist before signing the statement of understanding and consent for care.

Patient Declaration
The therapist has explained to me the treatment for my condition, the expected benefits and complications possible, any discomfort or risks that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist or therapy assistance or techs (under direction of a therapist) to render treatments to me.

THERAPIST RIGHT TO REFUSE TREATMENT
A therapist reserves the right to refuse treatment for any reason, including if they feel unsafe.

Patient/guardian signature: ____________________________________ Date: _______________

Relationship to patient: ______________________________

Witness: __________________________________ Title: ________________________________

ON THE GO PHYSIO

COMMUNICATION PREFERENCES

Preferred Contact Information

Primary Telephone:_________________________ Cell ____ Home ____ Work ____

Secondary Telephone: _______________________ Cell ____ Home ____ Work ____

____ OK to leave message with detailed information

____ Leave message with call back number only

Text and email have an inherent risk of PHI (protected health information) potentially being compromised. Despite this, most patients prefer the ease of communication with text or email. Please check below to consent communication via text and email.

____ OK to communicate via text

____ OK to communicate via email

____ encrypted email only

I understand that I have the right to change this authorization at any time.

Patient/Guardian Signature: ______________________________________ Date: ______________

ON THE GO PHYSIO

PERMISSION TO RELEASE MEDICAL OR FINANCIAL INFORMATION

Patient Name:_____________________________________ DOB: ______________

We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition, diagnosis, and scheduling of appointments. Please update this information promptly if your preferences change.

I authorize the release of information to:

Name: ______________________________ DOB: _________ relationship: ________________

Name: ______________________________ DOB: _________ relationship: ________________

Name: ______________________________ DOB: _________ relationship: ________________

___ Check here if you do not want your information released to anybody

I understand that I have the right to change this authorization at any time.

Patient/Guardian Signature: ____________________________________ Date: _____________

ON THE GO PHYSIO

PATIENT RESPONSIBILITY FOR THERAPY SERVICES

On The Go Physio is a cash based practice, and currently does not accept insurance. Acceptable forms of payment include cash, check, and credit/debit card. Rate is $120/hour. Billing is done in 15 minute increments. Session times are rounded up/down based on the time clock method of billing. For example:

Session Time	Cost
8-22 minutes = 15 minutes billed	$30
23-37 minutes = 30 minutes billed	$60
38-52 minutes = 45 minutes billed	$90
53-67 minutes = 60 minutes billed	$120
68-82 minutes = 75 minutes billed	$150
83-97 minutes = 90 minutes billed	$180

The rate for a semi-private session is calculated the same way, but is only $90/per person, per hour.

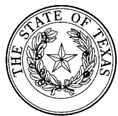
These prices are all-inclusive, and there is no additional cost for exercise bands or tape applications.

PAYMENT IS DUE AT TIME OF SERVICE

I, the patient or guardian, have read this form and fully understand my financial responsibility as it pertains to therapy services and any additional charges I may incur.

Patient/Guardian signature: ____

Witness: ____ Date: ________________



Texas Board of Physical Therapy Examiners

333 Guadalupe, Ste 2-510 ***512/305-6900 • 512/305-6951 fax***
Austin, Texas 78701-3942 ***http://www.ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): ____

____ ____________________
Signature of Patient or Legal Representative Date

____
If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019
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ON THE GO PHYSIO

Parental Authorization for Physical Therapy Services

Name: ____ DOB: __________________

Parent/Guardian: ____ □ Parent □ Legal Guardian
Physician: ____ Date: _______________

I hereby give authorization for my child to be seen by the physical therapist with or without a parent or legal guardian present. This authorization includes performance of any diagnostic, therapeutic, or other necessary physical therapy services as deemed appropriate by the treating physical therapist and/or physical therapy assistant.

Parent/ Legal Guardian's Signature __________________________ Date: ____________