THE PHYSICAL THERAPY INSTITUTE®
ORTHOPEDICS AND SPORTS MEDICINE

PRINT NAME: _____

We're happy you're here. Did you hear about us from a friend, through our advertising, or did you see a sign and decide to pop in? Tell us about it! Select ONE below:

- ☐ Returning Patient
- ☐ Facebook/Social Media
- ☐ Workshop
- ☐ Newspaper
- ☐ Our Website
- ☐ Patient Newsletter
- ☐ Flyer/Poster/Signage
- ☐ "Physical Therapy" search on Google/Bing/Yahoo

Please specify :

_____

☐ Family/Friend : _____

☐ Physician: _____

(please give name to give them credit)

I agree to and accept emails and text messages.

Email: _____

Signature: _____

Date: _____

MFES - Initial Visit

Today's Date: ____/____/____ Date of Birth: ____/____/____

Name: _____

Please rate your pain level with activity:

0	1	2	3	4	5	6	7	8	9	10

NO PAIN VERY SEVERE PAIN

INSTRUCTIONS: On a scale of 0 to 10, how confident are you that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure"?

If you have stopped doing the activity at least partly because of being afraid of falling, score a 0;
If you have stopped an activity purely because of a physical problem, leave that item blank
If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate if you had to do the activity today.

	NOT CONFIDENT AT ALL				FAIRLY CONFIDENT					COMPLETELY CONFIDENT
1. Get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10
2. Prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10
3. Take a bath or a shower	0	1	2	3	4	5	6	7	8	9	10
4. Get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10
5. Get in/out of bed	0	1	2	3	4	5	6	7	8	9	10
6. Answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10
7. Walk around the inside of your house	0	1	2	3	4	5	6	7	8	9	10
8. Reach into cabinets or closet	0	1	2	3	4	5	6	7	8	9	10

	NOT CONFIDENT AT ALL				FAIRLY CONFIDENT					COMPLETELY CONFIDENT
9. Light housekeeping	0	1	2	3	4	5	6	7	8	9	10
10. Simple shopping	0	1	2	3	4	5	6	7	8	9	10
11. Using public transport	0	1	2	3	4	5	6	7	8	9	10
12. Crossing roads	0	1	2	3	4	5	6	7	8	9	10
13. Light gardening or hanging out the washing*	0	1	2	3	4	5	6	7	8	9	10
14. Using front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10

* RATE MOST COMMONLY PERFORMED OF THESE ACTIVITIES

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

480 Johnson Road, Suite 303, Washington, PA 15301

NAME: _____ DOB: ____/____/_____

ADDRESS: _____ GENDER: M F

_____ SS#: _____-_____-_____

HOME PHONE: _____ PHYSICIAN: _____

WORK/CELL: _____ PHYSICIAN PHONE #: _____

Email: _____

INSURANCE

PRIMARY: _____ SECONDARY: _____

POLICY/CLAIM#: _____ POLICY/CLAIM#: _____

GROUP#: _____ GROUP#_____

SUBSCRIBER: SELF SPOUSE PARENT SUBSCRIBER: SELF SPOUSE PARENT

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____/_____/_____ SUBSCRIBER DOB: ____/____/_____

*HAVE YOU RECEIVED HOME HEALTH IN THE PAST MONTH: YES NO

*HAVE YOU RECEIVED CHIROPRACTIC TREATMENT IN THE LAST YEAR: YES NO

*IS THIS A WORK INJURY: YES NO EMPLOYER: _____

*IS THIS AN AUTO INJURY: YES NO STATE THAT ACCIDENT OCCURRED IN: _____

PATIENT: I HAVE REVIEWED THE ABOVE INFORMATION AND IT IS CORRECT: YES NO Initials: _____

OFFICE USE ONLY: APPOINTMENT: DAY:_____DATE: _____/_____/_____ TIME: _____

Effective Date:__/__/__ Benefit Year:___/___/___to___/___/___ Effective Date:__/__/__ Benefit Year:___/___/___to___/___/___

Copay: _____Coin:_____Ded_____ met?_____ Copay: _____Coin_____Ded_____met?_____

AUTH: □None □Now - Tmt Plan Y N □Later – After visit #_____ AUTH: □None □Now - Tmt Plan Y N □Later – After visit #_____

VISIT LIMIT: □None □per cap □_____per calendar/benefit year VISIT LIMIT: □None □per cap □_____per calendar/benefit year

VERIFIED: _____/_____/_____ BY: _____ *If Medicare supplement, pays Part B Coin Y N Ded Y N

Comments_____

Type of Insurance: □BC □Commercial □WC □Auto □Medicare □Medicare Supplement □Self

PHYSICAL THERAPIST: Date of Injury: _____/_____/_____

Dx. Codes: 1)_____ 2)_____ 3)_____ 4)_____

THE PHYSICAL THERAPY INSTITUTE℠
ORTHOPEDICS AND SPORTS MEDICINE

PAST MEDICAL HISTORY FORM

NAME: _____ **AGE:** _____ **GENDER:** M F

EMAIL: _____

EMERGENCY CONTACT NAME: _____ **EMERGENCY CONTACT PHONE:** _____

PAST MEDICAL HISTORY (Check all that apply)

_____ HEART ATTACK	_____ NECK/BACK PAIN	_____ CANCER
_____ STENT	_____ SHOULDER PAIN	_____ ULCERS
_____ TRANSPLANT	_____ ELBOW/WRIST/HAND PAIN	_____ ARTHRITIS
_____ ANGINA/CHEST PAIN	_____ FOOT/ANKLE PAIN	_____ DIZZINESS/VERTIGO
_____ DEPRESSION	_____ OSTEOPOROSIS	_____ FAINTING
_____ CONGESTIVE HEART FAILURE	_____ DIABETES	_____ HIGH BLOOD PRESSURE
_____ PERIPHERAL VASCULAR DISEASE	_____ ASTHMA	_____ APPETITE CHANGES
_____ KNEE PAIN	_____ STROKE	_____ PACEMAKER

_____ PRIOR SURGERIES (LIST ALL): _____

_____ ALLERGIES (LIST ALL): _____

IN THE PAST THREE MONTHS, HAVE YOU HAD OR DO YOU EXPERIENCE:

_____ NAUSEA/VOMITING	_____ FEVER/CHILLS/SWEATS	_____ NUMBNESS/TINGLING
_____ APPETITE CHANGES	_____ UNEXPLAINED WEIGHT CHANGE	_____ SHORTNESS OF BREATH
_____ DIFFICULTY SWALLOWING	_____ BOWEL/BLADDER CHANGES	_____ FEVER
_____ DIFFICULTY SLEEPING/NIGHT PAIN	_____ BRONCHITIS	_____ KIDNEY DISEASE

I CURRENTLY HAVE DIFFICULTY (Check all that apply)

_____ VISION _____ HEARING _____ SPEECH

LIST ANY MEDICATIONS WITH DOSAGE YOU ARE CURRENTLY TAKING:

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

THERAPIST SIGNATURE: _____ **DATE:** _____

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE
480 Johnson Road, Suite 303, Washington, PA 15301

INSTRUCTIONS:

1. Draw each area of your pain or other symptoms onto the chart.

2. Choose the corresponding numbers and letters from the lists below to describe your symptoms or use your own words.

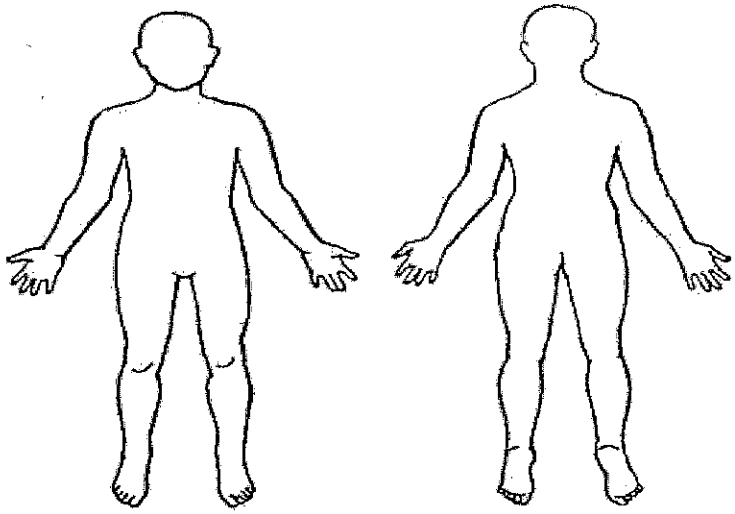
****

THIS LIST PROVIDES SOME EXAMPLES OF WORDS THAT MAY HELP DESCRIBE YOUR PAIN. __ USE ALL THAT APPLY:

#1 Sharp	#5 Throbbing	#9 Heavy
#2 Shooting	#6 Ache	#10 Tight
#3 Burning	#7 Tingling	#11 Pulling
#4 Dull	#8 Numb	#12 Stabbing

THIS LIST PROVIDES WORDS THAT MAY HELP DESCRIBE THE BEHAVIOR OF YOUR SYMPTOMS. USE ALL THAT APPLY:

A: constant (never goes away) B: intermittent
(relieved with some positions or rest) C: occasionally (daily or less frequently)
D: infrequently (once a week or month)
E: previously (no longer present) F: variable
(sometimes worse than othertimes)



FRONT **BACK**

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE
480 Johnson Road, Suite 303, Washington, PA 15301

INFORMED CONSENT DOCUMENT

I affirm that I explained to _____
(patient's name)

on_____, 201__ the following:

diagnosis, benefits of treatment, type of treatment, prognosis, inherent risks, reasonable alternatives, risks of refusing treatment, and the possibility of future changes in the plan of care. The patient has agreed to Physical Therapy Treatment by The Physical Therapy Institute.

The patient's questions were all answered and I received informed consent for the stated plan of care and for future changes in the plan of care providing that I continue to explain the above information.

Patient's Signature_____

Therapist's Signature_____

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

Notice of Protected Health Information Practices (Privacy Policy)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), THE PHYSICAL THERAPY INSTITUTE ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

c. Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

d. Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

The effective date of this Notice is 11/04/2013.

k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. Uses and Disclosures to Business Associates. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. Right to an Accounting of Disclosure of Your Health information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. When Authorizations are Required. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. Right to Revoke Your Authorization. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. Right to Opt-Out of Fundraising Communications. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at or sending an email to rchristoff@pt-institute.com with your instructions to opt out of fundraising communications.

10. Right to be Notified Following a Breach of Your Information. If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

11. Right to Receive Copy of this Notice. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (724) 223-2061. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at (724) 223-2061. All complaints must be submitted to the Practice in writing at 480 JOHNSON ROAD, WASHINGTON, PA 15301. There will be no retaliation for filing a complaint.

The effective date of this Notice is 11/04/2013.

THE PHYSICAL THERAPY INSTITUTE

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by THE PHYSICAL THEAPY INSTITUTE (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 480 JOHNSON ROAD, WASHINGTON, PA 15301, Attention: Compliance Officer
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature of Patient or Representative _____ Date: _____

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Name of Personal Representative (if applicable) _____ Relationship to Patient: _____

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

Accepted Denied Not Applicable

Other (explain) _____

Signature of Authorized Practice Representative: _____ Date: _____

PTI THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. **We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not.** Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- **PTI requires 24 hours-notice in the event of a cancellation.** It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

- **There maybe a $25 charge for a cancellation without proper notice.** This charge will NOT be covered by insurance but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- **Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.**

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

_____ _____

Patient Signature Date

_____ _____

Interviewer Signature Date

THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize The Physical Therapy Institute to disclose my health information that is directly related to my current treatment at The Physical Therapy Institute to the individual(s) listed Below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

In the event we cannot reach you, may we leave a message on your answering machine: __Yes __No

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request the notice if one is not provided to me.

Signature:_____ Date:_____