Dynamic Physical Therapy
Demographic Form

Full Name: _____ Preferred Name: _____

Birth Date: _____ Gender: ☐ male ☐ female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Phone: _____ Name/Relationship to you: _____

Occupation: _____ Employer: _____

Work Phone: _____ Employment Status: _____

Social Security Number (for billing your insurance) _____

Email Address: _____

**By giving us your email address, you are joining the Dynamic Physical Therapy community and will get the latest communications on healthcare and other relevant physical therapy information. You can unsubscribe at any time and we will NOT share your information with outside parties.

Name of physician who referred you: _____

How did you hear about Dynamic Physical Therapy?

_____ Friend _____ Returning Patient _____ Physician _____ Phone Book
_____ Email _____ Internet/Website _____ Other, Please Explain _____

Are you seeing us for a work injury or auto accident injury: ☐ yes ☐ no
➔ *If yes, we will ask you for specifics after you return this form.*

Medicare patients only:
➔ Are you currently receiving any services from a home health agency (nursing, aide, therapy, speech, any in-home assistance)? ☐ yes ☐ no

Primary insurance company: _____
Policy holder's name & date of birth: _____

Secondary insurance company: _____
Policy holder's name & date of birth: _____

Please describe what we are seeing you for today: _____
_____
_____

Dynamic Physical Therapy
Medical History Form

Do you have heart or blood vessel problems?	☐ yes	☐ no
Do you have diabetes?	☐ yes	☐ no
Do you have lung or airway problems?	☐ yes	☐ no
Do you have kidney or liver disease?	☐ yes	☐ no
Do you have balance problems?	☐ yes	☐ no
Are you depressed?	☐ yes	☐ no
Do you have persistent joint or muscle pain?	☐ yes	☐ no
Are you sleeping well?	☐ yes	☐ no
Do you exercise weekly?	☐ yes	☐ no
Do you have bowel or bladder problems?	☐ yes	☐ no
Do you have an autoimmune disease?	☐ yes	☐ no
Do you have cancer?	☐ yes	☐ no
Do you have a neurological condition?	☐ yes	☐ no
Have you had surgery recently?	☐ yes	☐ no
Do you have vision or hearing loss?	☐ yes	☐ no
Do you have loss of feeling anywhere on your body?	☐ yes	☐ no
Are you seeing other medical providers at this time?	☐ yes	☐ no
Do you have allergies?	☐ yes	☐ no
Do you smoke ?	☐ yes	☐ no
Do you have osteoporosis?	☐ yes	☐ no
Have you been diagnosed with arthritis?	☐ yes	☐ no
Are you pregnant?	☐ yes	☐ no
Do you have shortness of breath?	☐ yes	☐ no
Do you have a pacemaker or other implants?	☐ yes	☐ no
Are you taking medication?	☐ yes	☐ no

Please list your medication(s) below or provide your own list:

_____

_____

Please add any additional medical history or other things you'd like us to know:

_____

_____

Patient Name: _____

Signature: _____

Date: _____

PT initials:

Dynamic Physical Therapy
Consent Form

Patient Name: _____

Consent to evaluate and treat.

Initials:

I consent to physical therapy services at Dynamic Physical Therapy. I understand that if I have any questions or concerns about my care I should ask my therapist. I know it is up to me to inform the physical therapist about any health problems, diseases, illnesses or allergies I have. I must also tell the physical therapist about drugs/medications I am taking, if I have a pacemaker/metal implants or if I am pregnant.

Consent to contact and bill insurance.

Initials:

I authorize Dynamic Physical Therapy to work with my insurance company to determine my coverage for physical therapy. I understand it is my responsibility as a patient to know my insurance coverage. I permit Dynamic Physical Therapy to bill and receive payments from my insurance company directly. I understand that I am responsible for co-payments and deductibles as dictated by my insurance policy. I also may be responsible to pay for charges my insurance company considers "non payable" treatment codes.

Consent to release personal health information.

Initials:

I give permission to Dynamic Physical Therapy to release my personal health information to obtain payment for provided services. I also allow the release of personal health information to my physician and other professionals who take part in my care. I have been provided with a copy of Dynamic Physical Therapy's Privacy Notice.

Patient signature: _____

Date: _____

Signature of patient representative: _____

Relationship to patient: _____

Date: _____

Dynamic Physical Therapy
Privacy Notice regarding protected health information (PHI)

This privacy notice is required by law to maintain the privacy of your protected health information and to provide you with a copy of this privacy notice. We reserve the right to make changes to the privacy notice.

We may disclose your health information in the following scenarios:

- To other health care providers within our practice for the purpose of treatment, internal operations or payment.
- To your physician or other health care provider involved in your care.
- To your insurance companies.
- To comply with Michigan State Workers' Compensation laws if applicable.
- To your emergency contact or other family member in the event of an emergency.
- To public health authorities as required by law where it concerns: preventing or controlling the spread of disease, reporting child abuse or neglect, reporting domestic abuse, reporting to the FDA for problems with product, and reporting disease or infection exposure.
- For law enforcement purposes and judicial proceedings.
- To coroners or medical examiners.
- To health oversight agencies.
- To organizations involved in organ transplant operations.
- To government functions related to military and veteran activities, national security and intelligence operations, correctional institutions, and law enforcement custodial situations.

For any other disclosures of your PHI we require your written authorization.

We may leave a message on your answering service regarding your appointment(s). We may contact you by phone, email or letter for informational and educational purposes, like telling you about a new service we provide.

You have the following rights:

- To inspect and copy your protected health information in paper format, except those pieces that, under federal law, you may not inspect or copy.
- You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment and operations.
- If you choose to pay for our services, in full, without involving third party payers, you may request that we don't disclose any of your PHI.
- You may also request that we not disclose certain aspects of your protected health information to family members or friends involved in your care.
- To request confidential communications by alternate means or at an alternate location regarding any aspect of your protected health information.
- To have corrections of your protected health information by authorized persons such as your physician, physical therapist, etc.
- To receive an accounting of certain disclosures of your protected health information made by this practice. This right applies to disclosures for purposes other than treatment, payment or operations.
- To obtain a copy of this privacy notice.

All requests regarding the above rights need to be made in writing, contain specific actionable information, and addressed to the Privacy Officer whose contact information is included on this form. Please note that we may deny your request and you have the right to appeal that denial.

If you have any question regarding this privacy notice please contact our compliance officer:

Compliance Officer
Dynamic Physical Therapy
8872 Professional Drive, Suite C
Cadillac, MI 49601
(231) 876-0010

You also have the right to express complaints to the Secretary of Health and Human Services.

I have read the Privacy Notice and understand my rights. I authorize Dynamic Physical Therapy to use and disclose my protected health information for purpose of treatment, payment and operations as outlined in this Privacy Notice

Name:_____

Signature:_____

Date:_____

This privacy notice took effect May 1, 2012