Please list any activities that make your symptoms worse: _____

_____

_____

Please list any activities that make your symptoms better: _____

_____

_____

What is YOUR goal for physical therapy? _____

_____

_____

HIPAA Acknowledgment/Consent

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for "Hands-on-Physical Therapy". In addition, I hereby consent to use of disclosure of my personal health information for the purpose of treatment, payment and health care operations.
I hereby give permission for the Therapist to speak to:_____

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

Patient Consent For Treatment:(Read thoroughly and sign below)

Having presented myself to "Hands-On Physical therapy" for testing and/or physical services, I do voluntarily consent to rendering of the medical testing or treatment procedures for which I am registering. I acknowledge that the service for which I am registering have been ordered by my physician. I understand the "HOPT" personnel will carry out my physician's orders and that no guarantees or assurances have been made regarding the results or effects of these services. I accept responsibility for all charges incurred as a result of these services and agree to pay any fees not covered by insurance. Should my account be sent to collections agency, I understand that I am responsible foe all collection fees and legal fees"HOPT" incurs through the procedures utilized to collect delinquent balances.
I hereby authorize"HOPT" to release such information as required my attorney and/or insurance company to secure my insurance benefits. In consideration of the services to be rendered, I hereby assign and transfer to "HOPT" any benefits payable to or for my benefits under hospitalization, sickness or accident insurance and any other insurance coverage for the payment of such services rendered. I agree to cooperate, aide and assist "HOPT" in producing all possible benefits including initiation of all policy provisions such insurance companies may require for payment.

Patient's Signature_____ Date_____

Parent/Legal Guardian and/or Guarantor