Shepherd Integrative Physical Therapy

Appointment Information and Forms

Below is important information you will need regarding your upcoming appointment. Please call or email if you have any questions prior to your appointment.

- I**ntake Forms:** Please print, complete, and bring the following forms to your appointment. Please note, even injuries or illnesses that may seem unrelated to your current symptoms are very important for me to know.

- **Check in:** Please check in with the attendant in the waiting room.

- **Payments:** Payment is due at the time services in the form of cash, check, (please make out to Shepherd Physical Therapy, PLLC), or credit card. We also accept HSA and FSA cards.

- **Insurance:** We are not contracted with any medical insurers, however, you may be eligible for insurance reimbursement depending on your **Out of Network Outpatient Physical Therapy** benefits. We will provide invoices for insurance reimbursement, as well as Flexible Spending Account and Health Savings Account reimbursement, upon request. **We are not a Medicare Provider,** so law prevents us from providing Medicare patients with what would be considered "normally covered services." If you are a Medicare beneficiary and would still like to request treatment, please call us.

- **Cancellation Policy:** If you must cancel or change an appointment, we request that you give me a **24 hour notice** prior to your scheduled appointment time by calling (720-270-5022) or email (info@wholebodypt.com). There will be a **$50.00** cancellation fee if we are not given 24 hour notice. Emergency situations will be taken into consideration.

- **What to bring/wear**: Bring any relevant medical reports including CDs of xrays/MRIs. Bring or wear flexible comfortable clothes that allow us to view and treat your body…i.e. workout shorts/pants, tank tops for women, sold and new (running/walking/cycling/etc.), and any orthotics.

- **Home Exercise Photos**: Many clients have found it helpful to have photos taken of them doing prescribed home exercises during their appointments to ensure memory of proper form/technique. Bring a cell phone or camera to your session if you are interested in having photos available for your personal use.

- **PT and PT Student Observation**: On occasion, we have other therapists and students who wish to observe our treatment approach. Please let us know if there would be any concern if they were to observe your appointment.

Office
1746 Cole Boulevard, Suite 225
Lakewood, CO 80401

Contact
720-270-5022
info@shepherdipt.com
www.shepherdipt.com

Shepherd Integrative Physical Therapy

1. Physical Therapy Consent to Treatment

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Benefits: may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

2. Cancellation Policy:

If you must cancel or change an appointment, we request that you give us 24 hour notice prior to your scheduled appointment time by calling (720-270-5022) or email (info@shepherdipt.com). There will be a $50.00 cancellation fee if we are not given 24 hour notice.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Patient's signature: _____

Print name: _____

Date: _____

Therapist's Signature/Date: _____

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Shepherd Integrative Physical Therapy/Shepherd Physical Therapy, PLLC

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Billing: If you submit an invoice to your health plan for reimbursement, your health plan will be informed of dates of services and the procedure codes on that invoice. We will not use or disclose any medical information to your health plan without specific written authorization from you.

If you have any question about any of our policies or your rights, please feel free to ask us.

Your signature below indicates your understanding and acceptance of the above privacy practices.

Patient's signature: _____

Print name: _____

Date: _____

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Questionnaire

Date:_____

Name (last): _____(first): _____

Address:_____City_____Zip_____

Best Contact Phone Number: _____ Alternate number: _____

Email: _____ Occupation:_____

Emergency Contact/phone:_____

Date of Birth:_____Age:_____

Primary Care Physician:_____ Phone:_____

Allied Health and Fitness Providers (chiropractor, orthopedist, pilates instructor, personal trainer, etc)

Provider: _____Phone:_____

Provider: _____Phone:_____

Provider: _____Phone:_____

Referred by: _____

Symptom/Specific Complaint Information

1. Personal history of past injuries (falls, car accidents, fractures, sprains, concussions): Please describe:

_____

_____

_____

2. Have you had any surgeries? What were they and when?

_____

_____

_____

3. Please check and describe if you have experienced any of the following.

_____ Numbness/Tingling/Weakness
_____ Weight Loss or Gain
_____ Fever
_____ Shortness of Breath/Cough/Asthma
_____ Chest Pain/Heart/Blood Pressure
_____ Urinary Tract Infections, Stones
_____ Vision/Hearing Loss
_____ Urinary Tract Infections, Stones
_____ Depression/Anxiety
_____ Cancer
_____ Gastrointestinal disorders
_____ Kidney/Liver/Gallbladder disorders
_____ Communicable Disease (Hepatitis, TB)
_____ Skin Lesions or Rash

4. Are there any other medical conditions that we should be aware of?

_____

5. Have you ever had any major illnesses?

_____

6. Do you have any food allergies or sensitivities?

_____

7. All current medications and supplements:

_____

_____

_____

8. Are you receiving treatment for any other medical conditions?

_____

9. How many hours per week do you exercise?

a. Biking: _____ b. Running: _____ c. Swimming: _____d. Weights: _____

e. Other (please describe): _____

10. What are your goals for therapy?

_____

_____

11. Describe your symptoms (please list below with details):

Concern #1:

a. When did this pain start? How did this pain start? What do you think caused it?

_____

_____

b. What activities or positions bring this pain on? How long can you do that activity before this pain comes on?

_____

c. Does it last after activity? With which activities and how long?

_____

d. Are there any positions/activities that help ease the pain, e.g., rest, ice?

_____

f. Since onset are your symptoms better, worse, the same? _____

g. Have you had treatment for this condition in the past? Yes No

If so, what type? _____
Was it helpful? Yes No

h. What is the intensity of your pain? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Concern 2:

a. When did this pain start? How did this pain start? What do you think caused it?

_____

_____

b. What activities or positions bring this pain on? How long can you do that activity before this pain comes on?

_____

c. Does it last after activity? With which activities and how long?

_____

d. Are there any positions/activities that help ease the pain, e.g., rest, ice?

_____

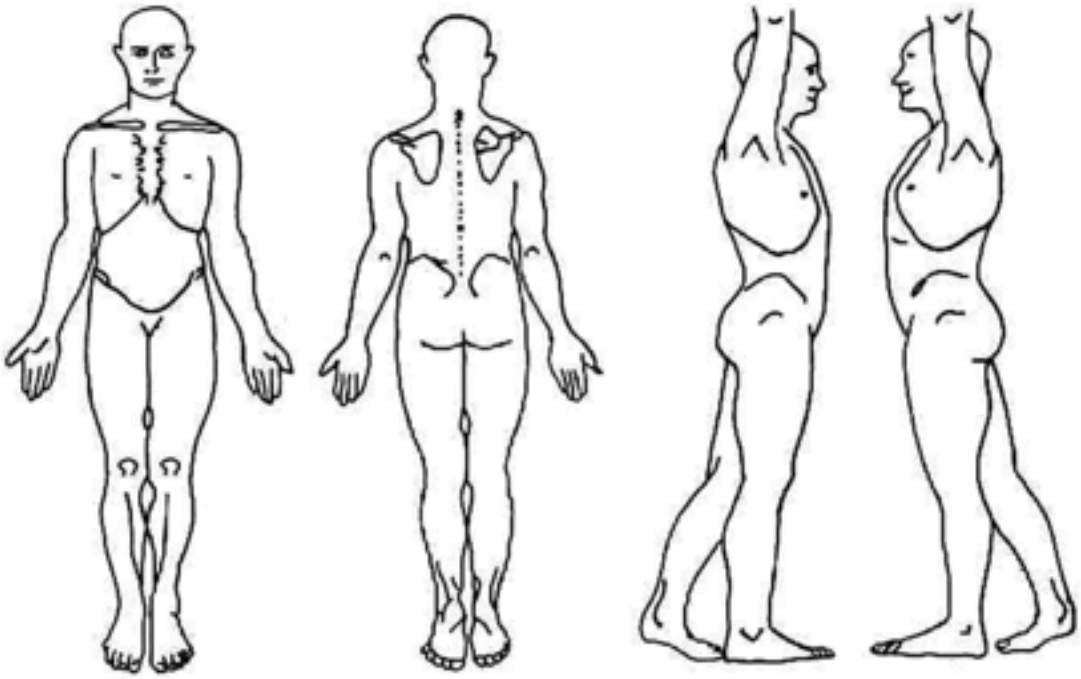
e. Since onset are your symptoms better, worse, the same? _____
f. Have you had treatment for this condition in the past? Yes No

If so, what type? _____
Was it helpful? Yes No

g. What is the intensity of your pain? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Please mark the locations of you pain/symptoms on the diagrams below.



Client Signature: _____ Date: _____