Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

Thank you for choosing Physical Therapy for Women!

Jennifer R. Shepherd, PT, CLT-LANA
Jennifer Albert, MSPT, CLT, CIDN
Beth Trinker, PTA, DPT • Briana Moorman, PT, DPT
Candice Brueck, PT, MPT,CLT • Brittany Reed, PT, DPT, CLT
Kristen Smith, PT, DPT • Rachel Christiansen, PT, DPT • Jolea Myles, PTA

Patient Name: _____ Nickname: _____
(First) (Middle) (Last)

Preferred Pronouns: ☐she/her/hers ☐he/him/his ☐ze/hir/hirs ☐they/them/theirs SSN: _____

Date of Birth:_____ Height:_____ Weight:_____ Marital Status: ☐Married ☐Single ☐Widowed ☐Other

Address: _____
(Street)

_____
(City) (State) (Zip code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Primary phone: _____

Would you like to receive appointment reminders: _____ If yes, by text, voice or email _____

Note that PTFW does not encrypt emails

Email address: _____ Would you like to be added to our email list? _____

Work Status: ☐Full time ☐Part time ☐Retired ☐Disability ☐Not Employed Employer: _____

Student Status: ☐Not a student ☐Full-time Student ☐Part-time Student

Referring Physician: _____ Return to Dr. Date: _____

Reason for PT evaluation: _____ Date of first symptom: _____

Primary Insurance Company and Policy #_____

Policy Holder's Name_____DOB_____

Policy Holder's relation to patient: Parent or guardian Spouse Dependant

Secondary Insurance Company and Policy# (if applicable) _____

Policy Holder's Name_____DOB_____

Policy Holder's relation to patient: Parent or guardian Spouse Dependant

Emergency Contact: _____ Emergency Contact Phone: _____

Relationship to patient: _____

HIPAA RELEASE OF MEDICAL INFORMATION AUTHORIZATION

☐ **No - I do not want to share any of my Personal Health Information with anyone who may call on my behalf. (Besides referring provider, insurance company/payor source).**

☐ **Yes - I give permission to the following people to have access to my PHI to include appointment info, PT care related information, and billing details.**

Name_____ Name: _____

Name_____ Name: _____

This permission remains in effect unless given additional request in writing to Physical Therapy for Women, Inc.

Patient Signature: _____ Date: _____

IMPORTANT: If you are currently receiving home health care, physical therapy, or chiropractic care, or have received physical therapy for any diagnosis this year, please let us know. This may affect your insurance coverage.

Please check and sign below:

☐ **Required: CONSENT TO TREAT:** I do hereby agree and give my consent for Physical Therapy For Women to furnish medical care & treatment that is considered necessary and proper in diagnosing or treating my physical condition.

☐ **Required: Chaperone Policy:** At PT For Women chaperones are offered to every patient regardless of the gender or role of the patient or clinician when performing sensitive evaluations or treatments. Sensitive evaluations or treatment include but are not limited to an evaluation, palpation, placement of instruments in genitalia, or exposure of: genitalia; rectum; breast. Pediatric patients, which include any patient under the age of 18 years of age, must have a chaperone present which does not include a family member/friend at every visit that occurs in a private treatment room .This is provided by PT for Women.

☐ **Required:** I have read and understand the financial policy given to me by *Physical Therapy for Women, Inc.*

☐ **Required:** I have read and understand the HIPAA Form.

☐ I am not currently receiving home health care, physical therapy, occupational therapy, speech therapy or chiropractic care for any other diagnosis.

****From the list above which type of care are you currently receiving? _____

☐ **MEDICARE PATIENTS** - Have you received physical therapy this year? If YES – How many visits did you attend? _____

☐ I authorize Physical Therapy for Women, Inc. to use my photographic image in marketing materials advertising our services that will be viewed by the general public. This includes PTFW's website, FaceBook page, and printed marketing materials. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

☐ I have completed the Credit Card Authorization form and I authorize *Physical Therapy for Women, Inc* to charge my credit card for agreed upon copayments/coinsurances. I understand that my information will be saved to file for future transactions on my account. I can cancel authorization at anytime by contacting the *Physical Therapy for Women, Inc* billing department

_____ _____

Patient signature **Date**