Authorization/Disclosure of information/consent to treatment form

Body Image Physical Therapy (BIPT) understands the importance of privacy. We are continuing to address compliance with federal HIPAA laws. It is important as patient that you are aware that BIPT is doing everything to maintain you privacy.

We will continue to work together with all of the professionals involved in your care to ensure you receive the highest quality treatment possible. This may entail verbal and written correspondence with your physician's office as we update them on your progress. It may mean exchanging information with your insurance company, attorney offices, or in the case of Worker's Comp, your employer. Should you require durable medical equipment or supplies, it may also mean giving information to medical supply distributors and/or 3rd party payers.

In the event that your primary physical therapist is absent, another qualified physical therapist will be responsible to treat your condition. Your information will be given only to that individual who has temporarily or permanently taken over your care.

Should any questions arise during the course of your treatment at BIPT you should speak with your treating therapist. By signing this form you are considering to care as outlined in your initial evaluation and in subsequent notes by your physical therapist. Every effort will be made to explain treatment procedure to you to ensure that you understand why the treatment is necessary.

If you have any questions about charges, billing procedures, your benefists or your statement beyond what has been explained to you by the clinic staff, you may call our billing department at 1-866-679-1600.

I have read and consent to the above:

Patient signature _____ Date _____

☐ Copy given to patient (By _____)

Body Image Physical Therapy is addressing HIPAA compliance

Body Image Physical Therapy
And
Saddle Rock Fitness

Informed consent and waiver of liability for personal fitness training and general use of the equipment

I expressly agree that all use of the combined Body Image Physical Therapy and Saddle Rock Fitness (hereafter, SRF) facility shall be undertaken by me at my own risk, whether I am engaging in an individual exercise session with a trainer or whether I am engaging in any unsupervised training session recommended or suggested by the trainer or other qualified staff members

Further, I understand that training sessions will require physical exertion, such as aerobic activity and resistance training. I recognize that exercise is not without some risk to the musculoskeletal system (may include: sprains, strains) and cardio-respiratory system (may include: dizziness, fainting, abnormal heartbeat, discomfort on breathing, abnormal blood pressure response and in rare cases, heart attack, stroke or death). I hereby acknowledge and accept these risks.

In signing this statement, I am aware of any physical or mental limitations, which would preclude me from participation in classes or training sessions. I understand that should I have a history of heart disease or cardio-respiratory complications or if I am currently taking medications for these conditions that I may not proceed with a training program without first obtaining written consent from my physician.

I understand that SRF shall not be liable for any injuries for damages to me or my property, and that SRF shall not be subject to any claim or demand for injuries of damages which result, either directly or indirectly, from my participation in a training session or a class, or by any use by me of the SRF equipment in any supervised or unsupervised training session. It is my understanding that staff trainers may not carry their own liability insurance, and that qualification of staff trainers are on file with SRF and are available for inspection at any time

I, for myself, and on behalf of my executors, administrators, and successors in interest do hereby expressly forever release and discharge SRF it's successors in interest and assigns, as well as its officers, directors, agents, and owners, for all such claims or demands for injuries or damage, resulting from my participation in any training session or class, both supervised or unsupervised, or any training session or class which has been recommended by the staff of SRF

I, _____ acknowledge that I have entered into an agreement with Body Image Physical Therapy and Saddle Rock Fitness, to participate in supervised and unsupervised training sessions and/or classes by qualified personnel.

Home Phone: _____ Member # _____

Signature: _____ Date: _____

Accepted by: _____ Date: _____

Describe any other conditions or precautions:

Medical and surgical history:

Body Region:	Surgery Type:	Date of Surgery:	&	Body Region:	Surgery Type:	Date of Surgery:
1				5		
2				6		
3				7		
4				8		

Current Medication:

If you have a medications list, please give it to us to scan in your file. If not, please list your medications here:

Drug:	Dosage:	Reason for taking:

Measures:

Please rate your pain on scale of 0 to 10 in the last 24 hours: 0 is no pain and 10 is the worst imaginable, passing out because the pain is so bad:

In the last 24 hours, at ***BEST*** my pain is at (please circle): 0 1 2 3 4 5 6 7 8 9 10

In the last 24 hours, at ***WORST*** my pain is at (please circle): 0 1 2 3 4 5 6 7 8 9 10

Please fill in how many min/hours you can do the following **comfortable.**

_____ sit _____ walk _____ stand _____ sleep _____ work at computer

Please check Activities that have been affected by you current problem:

_____ bathing, hygiene _____ cooking/meal preparation _____ dressing tasks

_____ getting up from chair _____ lifting/carrying __ lbs _____ any overhead activity

_____ household tasks _____ driving _____ stairs

Name_____

Reason for referral: what problem brings you to us today? _____

Date you problem began _____ or date your injury/MVA occurred _____

What alternative treatments have you tried such as chiropractic, acupuncture, magnetics, other therapies? _____

_____

Please mark any tests, dates of tests and known results for this problem:

Tests:	Date:	Results:
X-rays		
MRI		
EMG		
CT scans		
Other:		

Occupation: _____

While at work: _____% sitting _____% standing _____% walking _____% lifting (up to _____ lbs)

You describe your goal for physical therapy as restoring the ability to: (**Please** pick one)

_____ Perform care-giving tasks with less pain. _____ Perform household tasks with less pain.

_____ Perform work-related tasks with less pain. _____ Perform fitness-related tasks with less pain.

_____ Perform school activities with less pain. _____ Perform recreational activities with less pain.

Your primary fitness activity involves what activity _____performed on average ___ x week/month

OR ____ I am not on a regular exercise program.

Medical history	***yes***	***no***		***yes***	***no***		***yes***	***no***
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Muscular disease/Multiple sclerosis		
Anxiety			Fibromyalgia			Osteoporosis		
Arthritis			Fractures			Parkinson Disease		
Asthma			Gallbladders Problems			Rheumatoid Arthritis		
Autoimmune Disorder			Headaches			Seizures		
Cancer			Hearing Impaired			Smoking		
Cardiac Conditions			Hepatitis			Speech Problems		
Cardiac Pacemaker			High Cholesterol			Stokes		
Chemical Dependency			High/low blood Pressure			Thyroid Disease		
Circulation Problems			HIV/AIDS			Tuberculosis		
Currently Pregnant			Incontinence			Vision Problems		
Depression			Kidney Problems			Fall history: Injury as a result of a fall last year?		
Diabetes			Metal Implants			Two or more falls in the past year?		