AXIOS
PHYSICAL THERAPY

PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to Axios Physical Therapy to the evaluation and treatment of my condition by a licensed physical therapist. I understand the physical therapist will inform me of the expected benefits and possible complications or discomfort, and the steps to take at home to alleviate those symptoms. All questions will be answered to the best of the therapist's ability. I understand that the benefits and risks to all interventions will be explained and that I, the patient, hold the final judgment in such matters. I understand that in the state of Virginia, effective July 1, 2021, SB 1187 passed which allows for a qualified physical therapist to evaluate and treat patients without a referral under certain circumstances up to 60 days. Virginia Code § 54.1-3482.

If under 18, Parent/Guardian: _____

Relationship to Patient: _____ Parent/Guardian Date of Birth:_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to Axios Physical Therapy for medical services rendered. I understand that I am financially responsible for all charges. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due to the nature of physical therapy, your progress and full recovery are dependent on the physical therapist, and your active participation and commitment to your appointments.

CANCELLATIONS: If you need to cancel your appointment, please contact Axios Physical Therapy at least one day prior to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a cancellation fee of 75% of the visit will be assessed.

PHOTOGRAPHY/VIDEOGRAPHY AGREEMENT: I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Clinic Director.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical therapist) from Axios Physical Therapy may communicate with me via text or email regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this-document:

Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

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HIPAA Notice of Privacy Practices

Notice of Privacy Practice Describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations and for other purpose that are permitted or required by the law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you, and that relates to your past, present or future physical or mental health or condition and related health care services. 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. The record we create of the care and services you receive is needed so we may provide you with the best quality care and also comply with certain legal requirements.

Uses and Disclosures of Protected Health Information
We will use and disclose elements of your protect health information without your signed authorization for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist’s practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care with a third party. For example we would disclose your protected health information, as necessary, to another physical therapist’s involved in your care or to your referring physician to ensure that the physician has the necessary information to reevaluate, diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for continued physical therapy treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare operations: We may use or disclose as- needed, your protected health information in order to support the business activities of your physical therapist practice. These activities include, but are not limited to, quality assessment activities employee reviews activities, training of physical therapy students licensing, and conducting or arranging for other business activities. For example, we may disclose your (PHI) to physical therapy students that see patients at our office. We may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your (PHI) in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings: Law Enforcements: Coroners, Funerals Directors, and Organ Donation; Research; Criminal Activity: Military Activity and National Security; Workers’ Compensation; Inmates: Required Uses and disclosures: under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to Investigate or determine our compliance with requirements of the section 164.500.

Other Permitted and Required uses and Disclosures Will be made Only with Your Consent, Authorization or Opportunity to object unless required by the law.
Physicians You May revoke this authorization, at any time in writing, except to the extent that your physician or the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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HIPAA Notice of Privacy Practices (continued)

Your Rights
(The following is a statement of your rights with respect to your protected health information.)

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of protected health information not be described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.
Your physical therapist is not required to agree to restriction that you may request. If the physical therapist believes it is in your best interest to permit use and disclose of your (PHI), it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as proved in this notice.

Complaints
You may complain to us or to the secretary of the Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filling a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with an HIPPA Compliance Officer by phone at (703) 372-5716 or Department of Health and Human Services Mail, fax, email, or OCR Complaint Portal www.hhs.gov/ocr/hipaa/

PATIENT ACKNOWLEDGEMENT SUMMARY

I have read and fully understand Axios Physical Therapy's HIPAA Notice of privacy practices.

- I understand that Axios Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
- I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.
  - I also understand that Axios Physical Therapy will consider requests for restriction on a case by case basis.
  - I hereby consent to the use and disclosure of my personal health information for purposes as noted in Axios Physical Therapy's Notice of Information Practices.
- I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Printed Name:_____ Date: _____

Patient/Guardian Signature:_____ Date: _____

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PATIENT MEDICAL HISTORY FORM

Name:_____ DOB_____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zipcode: _____

Phone: _____ Email: _____ _____

Referring Physician:_____ Return Visit Date: _____

Body Part:_____ Date of Injury: _____ Date of Surgery: _____

Occupation:_____ Work Status: Employed ☐ Unemployed/Retired ☐

Hobbies:_____Prior Treatment: _____

What is the nature of the current injury?

☐ Work Related ☐ Chronic/Reoccurring ☐ Fall ☐ MVA

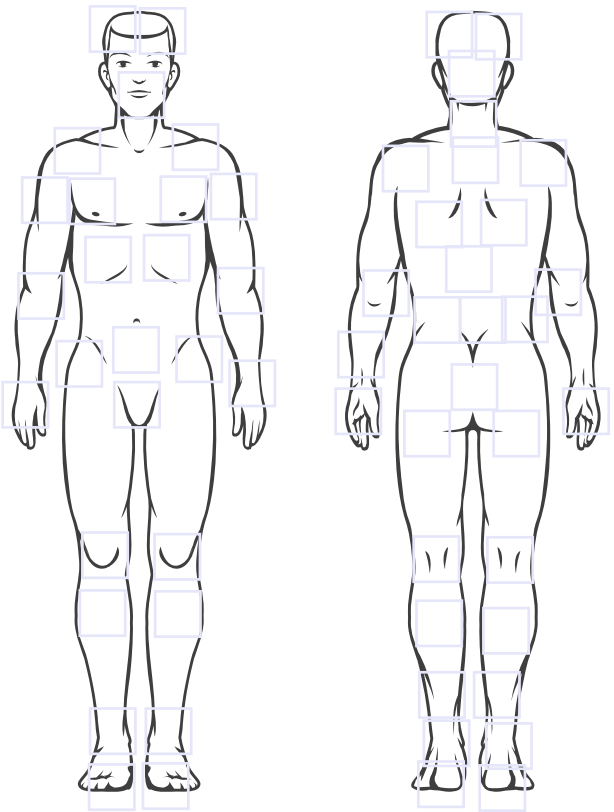
☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

What is your pain rating in the last 24 hours? 0-10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST POSSIBLE PAIN

Please use the diagram provided to mark where your symptoms are currently.



Pain Descriptors:

☐ Aching ☐ Burning
☐ Stabbing ☐ Numbness
☐ Pins & Needles ☐ Radiates
☐ Other_____

My symptoms are made better by: _____

_____

My symptoms are made worse by: _____

_____

My symptoms are:

☐ Constant ☐ Intermittent ☐ Chronic ☐ New

Are your work or activities of daily living limited?

☐ Yes ☐ Partial ☐ No

In addition to this paperwork, you will complete a functional outcomes scale.

PATIENT MEDICAL HISTORY FORM (CONTINUED)

List at least 3 activities that you are unable to do/having difficulty with as a result of your pain/injury AND rate them 0-10 (0 = unable; 10 = able to perform without issues)

1. _____ 0
2. _____ 0
3. _____ 0
4. _____ 0

How often do you exercise more than 20 minutes per day?

☐ 0x/wk ☐ 1x/wk ☐ 2x/wk ☐ 3x/wk ☐ 4x/wk ☐ 5x/wk ☐ 6x/wk or more

Do you smoke? ☐ Yes ☐ No

List any recent Diagnostics (*Xray, MRI, CT Scan, EEG, EMG, Injections*): _____

Do you have any allergies to latex, cold, heat or medications? ☐ Yes ☐ No If yes: _____

Are you on any medications? ☐ Please see attached list provided by the patient.

_____ _____ _____

_____ _____ _____

Have you fallen in the last year? ☐Yes ☐No If yes, how many times?_____

Did you sustain an injury when you fell, and if so, please describe:_____

Under what circumstances did you fall? (e.g. location, using assistive device, transferring, etc.)_____

_____

Past Medical History

Have you recently noted any of the following? (*check all that apply*)

☐ Changes in Bowel or Bladder	☐ Fatigue	☐ Nausea/Vomiting	☐ Shortness of Breath
☐ Constipation	☐ Fever/Sweats/Chills	☐ Numbness/Tingling	☐ Unexplained Weight gain/loss
☐ Difficulty Swallowing	☐ Hearburn/Indigestion	☐ Pain that wakes you at night	☐ Unexplained Cough
☐ Dizziness/Lightheaded	☐ Incontinence	☐ Rapid Heart Rate/Palpitations	☐ Visual Changes
☐ Fainting	☐ Muscle Weakness	☐ Recent Onset of Headaches	

☐Prior surgeries. Please describe: _____

Please check ALL that apply

Cardiovascular System:

☐ Lightheadedness	☐ Night sweats	☐ Leg cramps when walking several blocks
☐ High Blood Pressure	☐ Shortness of breath	☐ Heartbeat in abdomen when you lie down
☐ Chest pains with rest	☐ Excessive sweating	
☐ Pacemaker	☐ Heart disease	

Explain: _____

PATIENT MEDICAL HISTORY FORM (CONTINUED)

General:

- ☐ Cancer
- ☐ Surgeries
- ☐ Fever/Chills
- ☐ Unusual swelling/edema
- ☐ Other medical conditions

Endocrine System:

- ☐ Unexplained weight loss or gain
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Easy bruising

Blood Born Diseases:

- ☐ HIV
- ☐ West Nile Virus
- ☐ Hepatitis A, B or C
- ☐ Lyme's Disease

Explain: _____

Gastrointestinal & Urogenital System:

- ☐ Diarrhea or constipation
- ☐ Abdominal pain
- ☐ Pain or difficulty when urinating
- ☐ Leak urine w/cough, sneeze or exercise
- ☐ Changes in menstruation pattern (female)
- ☐ Currently pregnant

Integumentary System:

- ☐ Changes in skin color or nail integrity

Explain: _____

Nervous System/Musculoskeletal

- ☐ Gait or balance disturbances
- ☐ Dizziness
- ☐ Neurological problems/stoke
- ☐ Abnormal Numbness, pins, needles
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Changes in vision
- ☐ Arthritis /Joint problems
- ☐ Night pain
- ☐ Trauma
- ☐ Morning stiffness
- ☐ Prolonged use of corticosteroids

Explain: _____

Pulmonary System:

- ☐ Difficulty or labored breathing
- ☐ Prolonged cough
- ☐ Lung/Asthma Smoke/tobacco use

Explain: _____

Additional Health History NOT noted above

The above information I have provided is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: Relationship: Phone:_____

Name: Relationship: Phone:_____

Printed Name: Date: _____

Patient/Guardian Signature: Date: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Phone: _____ Relationship: _____

How did you hear of Axios Physical Therapy?

- ☐ Drive by location/signage
- ☐ Friend/Family/Patient
- ☐ Local Event
- ☐ Email or Text
- ☐ Google Search/Website
- ☐ Referred by Physician
- ☐ Employee Referred
- ☐ Referred by Chiropractor
- ☐ Returning Patient
- ☐ Free Injury Assessment
- ☐ Sports Club

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FEE SCHEDULE

1 HOUR EVALUATION	$180
1 HOUR FOLLOW-UP	$160
1 HOUR FOLLOWUP 4 PACK	$640
1 HOUR FOLLOW-UP 4+	$150/hr
30 MINUTE FOLLOW-UP	$85
PERSONAL TRAINING	$60
TELEHEALTH (30MINUTES)	$85