Medical History:

***Name:* ________________________________ *Birthdate:*___________**

*Reason for Visit:*____

*Referred by:*____

Have you ever been diagnosed with any of the following?

Cancer: Yes No If yes, what kind? ___________

Heart Problems: Yes No

Rheumatoid Arthritis: Yes No

Chemical dependency/alcoholism: Yes No

High Blood Pressure: Yes No

Osteoarthritis: Yes No

Anxiety or panic disorders: Yes No

Stroke: Yes No

Hepatitis/HIV/AIDS: Yes No

Depression: Yes No

Diabetes: Yes No

Neurologic Disease: Yes No If yes ________

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition. DATE SURGERY / HOSPITALIZATION REASON

____

____

____

What medications including prescriptions, herbal remedies and over the counter, in any form (pills, injections, skin patches) are you currently taking?

____

____

____

In the past 6 months, have you had:

Difficulty with bowel/bladder control: Yes No

Numbness: Yes No

Numbness in the genital or anal area: Yes No

Weakness: Yes No

Vision/hearing problems: Yes No

Dizziness or fainting: Yes No

Unexplained weight change: Yes No

Chest pain: Yes No

Other:

How did you hear about us?

____

MW PHYSICAL THERAPY
\+ SPORTS PERFORMANCE

Physical Activity Release and Waiver

*I, ____ hereby fully waive, release, defend, indemnify and hold harmless Low Five Productions, LLC, dba **Mandon Welch Physical Therapy and Sports Performance** and its employees, independent contractors, officers, directors, shareholders, members, affiliates, associates, agents, representatives, successors and assigns (collectively "Releasees"), from any and all claims, costs, demands, damages, (including, without limitation, actual and incidental damages), expenses, and causes of action ("Claims") with and in respect of any and all death, sickness, disease, bodily personal or other injury, and property damage arising from my participation in any and all activities or treatments, including but not limited to physical therapy, strength and conditioning, and training ("Activities") with Mandon Welch Physical Therapy and Sports Performance, notwithstanding that any such Claims may have been contributed to or occasioned by the negligence of any of the Releasees.*

I hereby consent to, and I am voluntarily participating in any and all Activities and hereby agree to indemnify and save and hold harmless the Releasees from and against any and all liability incurred by any or all of said Releasees arising as a result of, or in any way connected to my participation in such Activities. I hereby acknowledge and accept that the Activities, treatments, use of the equipment and facilities involves inherent risks of injury and death, of which I voluntarily accept at my own risk.

I have read and understand the foregoing and acknowledge my consent to the terms of this Release, and I hereby voluntarily, at my own risk, sign this Release in consideration of participating in and receiving the Activities and being permitted to use the facilities, equipment and property.

Signature of Client or Guardian:
____ Date: ____________
Client Name (Print): _______________________________________

Client Date of Birth:___________________________

Address:
____

Telephone: _________________

FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Low Five Productions, LLC, **Mandon Welch Physical Therapy and Sports Performance** for your physical therapy and performance training. We are honored by your choice and committed to providing you the highest quality physical therapy and training. Please read and sign this agreement to acknowledge that you understand our client financial policies, which are as follows:

1)The client (you) are ultimately responsible for all payment for treatments and training.

2)The client is responsible for all charges associated with insurance co-pays and non-covered charges.

3)The client is responsible for any costs associated with collections of unpaid client balances.

4)Client statements are mailed on a monthly basis. The client is responsible for making the payment within 30 days of the date that appears on client statement.

5)The client is aware and understands that failure to make payment for treatment or training will result in collection actions being taken to collect the debt.

6)

A $50.00 late cancellation fee will be charged for cancellations within 12 hours of scheduled appointment.

Client Authorization:

I hereby authorize assignment of financial benefits from healthcare and insurance entities directly to Mandon Welch Physical Therapy and Sports Performance for services provided as allowed under standard contracts. I understand and agree that I am financially responsible for all charges not covered. I have read, understand and agree to the terms of this Financial Responsibility Agreement.

Signature of Client or Guardian: ____

Date: ______________________________

Client Name (Print): ____

Waiver of Authorization: I choose to pay at the time of service and to be fully responsible for all charges and to submit claims to my insurance company at my own discretion.

Signature of Client or Guardian: ____

Date: ______________________________

Client Name (Print): ____

MW PHYSICAL THERAPY
+ SPORTS PERFORMANCE

HIPAA Compliance Patient Consent Form

Consent to Physical Therapy Evaluation and Treatment: *I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Mandon Welch Physical Therapy and Sports Performance. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will to the best of their knowledge, inform me of expected benefits and complications, any discomforts and risk that may arise, and the risk and consequences of no treatment.*

Patient Information Consent Form (HIPAA) *: I have been given the opportunity to read and fully understand Mandon Welch Physical Therapy and Sports Performance Notice of Information Practices. I understand that Mandon Welch Physical Therapy and Sports Performance may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations.*

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mandon Welch Physical Therapy and Sports Performance Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Mandon Welch Physical Therapy and Sports Performance has 30 days to respond to my request.

Release of Information: *I hereby authorize the release of information necessary to file claims with my insurance company. permit a copy of this authorization to be used in place of the original.*

Designated Individuals Authorization "*I, ______________________________________, hereby authorize one or all of the designated parties 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 will be verified by photo ID before the release of any information. If none, please print "none" below.*

Authorized Designees:

Name:____
Relationship:____________________

I have read and understand the above consents, release of information, and designated individual authorization above.

Signature of Client or Guardian:________________________ Date:____________
Client Name (Print):____