Johns Creek Physical Therapy, LLC
Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

SSN: _____ Employer/Occupation: _____

Marital Status: M S D W Spouse Name/Phone #: _____

Please initial after reading policies below:

____ **Photo and Written Release:** I hereby authorize Johns Creek Physical Therapy to use my likeness in a video, photograph or my written words as expressed on a Patient Results Form or Success Story in any and all of its publications including but not limited to Johns Creek Physical Therapy's printed and digital publications. (These include but are not limited to: monthly newsletters, website, blog posts, patient and physician mailers/brochures, wall photos, as well as Facebook, Instagram and Twitter posts) I acknowledge that since my participation with John Creek Physical Therapy is voluntary, I will receive no financial compensation or other benefits that could be construed as financial compensation. I hereby irrevocably authorize Johns Creek Physical Therapy to edit, alter, copy, exhibit, publish, and/or distribute my video, photo or written words for the purposes of promoting and publicizing Johns Creek Physical Therapy's programs or for any lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release Johns Creek Physical Therapy and its employees, directors, officers, agents, owners, successors, and Parent Corporation from any claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

___ **Cell Phones:** To be courteous to our staff and other patients, we ask that you turn your cell phone off. If you must use your cell phone, please limit your talk time so as not to disturb others around you.

___ **Insurance:** We will file your claims as a courtesy; however, the services rendered are charged to you. These charges are your responsibility and obligation. All co-pays are due at the time of each visit, unless other arrangements are made. We will verify your benefits for Physical Therapy, but this is not a guarantee of payment. You are responsible for any deductible and/or co-insurance your insurance plan deems to be your responsibility. If your insurance company has not paid within 60 days, *you agree to pay the outstanding balance.* We will attempt to get any authorization from your insurance if necessary; but it is your responsibility to confirm it is received.

___ **Consent to Treat:** I hereby consent to rehabilitation services at Johns Creek Physical Therapy, LLC. I agree to release Johns Creek Physical Therapy, LLC its employees and representatives from any liability from any personal loss or injury that may occur to me as a result of my treatment.

_____

Patient/Parent/Guardian Signature **Date**

Johns Creek Physical Therapy, LLC
Patient Medical History

Name: _____ DOB: _____ Age: _____

Referred by: _____ PCP: _____

Prescription Medications: _____

Allergies to Medications: _____

Surgical History: _____

Have you had physical therapy this year? Y N For what condition? _____

Medical History (check all that apply)

__Arthritis
__Broken Bones/Fractures
__Cancer
__ Diabetes
__ Heart Problems
__ Head Injury
__ High Blood Pressure
__ Parkinson's
__ Kidney Problems
__ Lung Problems
__ Osteoporosis
__ Seizures
__ Stroke
__ Multiple Sclerosis
__ Muscular Dystrophy
__ other: _____

Please explain above:
_____

Are you having any of these symptoms? (check all that apply)

__ Chest Pains/ Breathing Difficulty
__ Coordination Problems
__ Difficulty Sleeping
__ Headaches
__ Loss of Balance
__ Pain at Night
__ Visual Problems
__ Weakness

Are you pregnant? ___Yes __ No

What is your condition/injury? _____
When did the problem(s) begin? _____
What happened? _____
Have you had the problem(s) before? ___Yes ___ No
What makes problem(s) worse? _____
What makes problem(s) better? _____

Current Limitations (check all that apply):

__ Difficulty with walking
__ Difficulty with stairs
__ Difficulty with walking on rough ground
__ Difficulty with bathing, dressing, eating
__ Difficulty with chores, shopping, driving
__ Difficulty with work, school
__ Difficulty with recreational activities
My condition is better __ in AM __ in PM

Goals I want to achieve through physical therapy: _____
_____

I will advise the therapist if there are any changes in my physical condition that would alter my response to any question on this form.

_____
Patient/Parent/Guardian Signature Date

Johns Creek Physical Therapy, LLC
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____

I understand that Johns Creek Physical Therapy, LLC is a healthcare provider and may share my health information for treatment, payment and healthcare operations. I have been offered a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Johns Creek Physical Therapy, LLC has the right to change this notice at any time. I may obtain a current copy in the office or by contacting the Privacy Officer at (770) 622-5344. The current Notice of Privacy Practices contains updates required by the United States Department of Health and Human Services, Office of the Secretary Office for Civil Rights (OCR) compliance dated September 23, 2013.

I authorize Johns Creek Physical Therapy, LLC to also release my protected health information to:

Family members: _____

School or Employer: _____

Other: _____

_____
Patient/Parent/Guardian Signature Date

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (____ years of age) OR Patient is unable to acknowledge because: _____
_____

Patient/Parent/Guardian did not sign due to: ___ Language Barrier ___Refused to sign
Other: _____

_____
Patient /Parent/Guardian Signature Date

_____
Relationship to Patient if Relative or Legal Guardian

_____
Witness Date Witness Date

Johns Creek Physical Therapy

No Show / Same Day Cancellation Policy

Welcome to Johns Creek Physical Therapy, we're glad you are here.

We expect you to get the most out of your physical therapy visits.
Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals.

We stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.
One missed visit can significantly decrease your success and result in a more chronic problem.

We expect a minimum 24 hour notice if you cannot attend an appointment.
We will assist you in rescheduling an appointment because getting you results is our main goal.

Please read and sign at the bottom indicating you understand our No Show / Same Day Cancellation Policy and agree to adhere to the expectations listed below.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment with no less than 24 hour notice.
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. We understand an illness can strike at any time. Repeated cancellations for illness without a 24 hour notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time, dressed for your session, ready to begin at your scheduled treatment time.
6. We know traffic can be unpredictable. We expect that you will call if you are running late so we can be prepared for your late arrival.
7. Please be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
8. **Please note, you will be charged a $50 fee for ANY no shows and ALL cancellations that occur with less than 24 hour notice. This amount is your responsibility as insurance will not cover this fee.**
9. **To avoid the $50 fee, you simply need to call the office and provide at least 24 hours notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours Monday through Thursday 8 AM to 5 PM, Friday 8 AM to 4 PM.**

Thank you for reviewing this policy.
We look forward to working with you to meet your physical therapy goals.

Marc C. Stewart, PT, Owner

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

_____	_____	_____
Patient Name	Patient Signature	Date