TEAM IOWA | PHYSICAL THERAPY

PATIENT MEDICAL HISTORY AND INTAKE

Name (first last)_____Pronouns_____

Date of Birth_____Phone_____Email_____

Mailing Address_____Zip Code _____

Occupation_____Employer _____

Emergency Contact Name_____Phone_____ Relationship _____

*In case of an emergency, or if I cannot be reached, I am giving consent for this individual to be contacted regarding my treatment

How did you hear about us? _____

Primary/Referring Physician _____

Ailment(s) to be assessed _____

Start date of symptoms _____

Past surgeries related to current ailment?_____

Date of past surgery(s) _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize *Team Iowa Physical Therapy at 2400 N Dodge St Ste. B Iowa City, IA 52245* to release the information described below to:

_____

Name (first last, title) Clinic

*Please include titles i.e., MD, DPT, ARNP

Description of information to be released:

▢ Visit notes and protected health information provided to Team Iowa Physical Therapy on patient's behalf

▢ Other: _____

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services unless the services are at the request of the party to whom the protected health information will be disclosed, I also understand that if I revoke, the revocation will take effect on the day it is received in writing as explained in our notice of privacy practices as provided to you. Authorization to release information expires a year from the date signed on page 2

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Team Iowa Physical Therapy's Notice of Privacy Practices. I understand that Team Iowa Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and administrative operations related to treatment or payment. I authorize the release of information left in a voicemail or text message and understand there is some level of privacy risk associated with this form of communication. 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 Team Iowa Physical Therapy in writing. I also understand that Team Iowa Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests of restriction. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Team Iowa Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying Team Iowa Physical Therapy in writing at any time.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled to Team Iowa Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing, as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Team Iowa Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting actives of negligence.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent and authorize Team Iowa Physical Therapy, its agents, associates and employees, to provide care and treatments to me per program policy and/or as prescribed by my physician. A representative of Team Iowa Physical Therapy will explain my plan of care and answer my questions. I understand that the care plan may change and, if so, these changes will be discussed with me. I agree to notify Team Iowa Physical Therapy, my physician or others providing care of any adverse reactions or other significant events relating to my health. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition by Team Iowa Physical Therapy, its agents associates and employees. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient/guarantor. I have read, understand and agree to the terms of this agreement freely and voluntarily and intend by my signature that this be a complete and unconditional release of all liability to the greatest extent allowed by law.

Patient or Guardian Signature _____ **Date** _____