Osteopractic Physical Therapy
Carolinas

Patient Intake

Patient Name:_____ Email:_____
Street Address:_____City:_____State:_____Zip:_____
Cell Phone:_____ Home Phone:_____
Marital Status: **S / M / D / W** Date of Birth:_____ Sex: **F / M**
Primary Care Physician:_____
What Practice? _____ Phone:_____
Employer:_____ City/State:_____
Date of current Injury/Onset:_____ Work Related Injury? **Y / N** Automobile or Personal Injury? **Y / N**
Please briefly describe what you are seeking treament for:_____
_____
Previous Treatments? Physical Therapy? **Y / N** Chiropractor? **Y / N** Accupuncture? **Y / N** Other? _____
If yes, Where/When and was it sucessful?_____
Are you representated by an attorney regarding this injury? **Y / N** If yes, who? _____
Emergency Contact/Relationship:_____ Phone:_____
How did you hear about OPTC? _____

Informed Consent
By signing below, the patient gives permission for the physical therapy evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from the treatment(s). I understand the term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that I will receive education concerning the diagnosis, treatment and prognosis including anticipated goals at the initial visit. I will also be explained my plan of treatment and the options available for my condition at that time.

Use and Disclosure of Your Health Information/Privacy Practices
Your health information will only be used or disclosed by Osteopractic Physical Therapy of the Carolinas for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice including any administrative operations related to treatment or payment.

--Email--
Osteopractic Physical Therapy of the Carolinas may use my email to send occasional company newsletters containing relevant medical/rehab news and updates, deals or promotions. Email addresses will never be used by or given to 3rd parties for use outside of OPTC. You may opt out at any time.

Medicare Notice
Osteopractic Physical Therapy of the Carolinas has *NO* relationship with Medicare and therefore cannot accept out-of-pocket payments for services that would *normally be covered by Medicare*.

Payment
OPTC is a pay-for-service practice. You will be expected to pay for the services provided following the conclusion of each session. Cancellation of a scheduled appointment must be done at least 48 hours prior to the appointment time to avoid a fee consisting of the full cost of the treatment session.

I have reviewed this consent form and acknowledge that the information I provided is true and that I agree to the terms outlined. I certify that I am not a Medicare beneficiary (see above). I have been given the opportunity to review this form and ask any questions related to it. I give my permission to Osteopractic Physical Therapy of the Carolinas to use and disclose my health information in accordance with it.

_____
Please print your name

_____ _____
Signature Date