Hartnett Physical Therapy, LLC
Client Contact Information

Name:_____ Today's Date:_____

Address:_____ City, State, Zip:_____

DOB:_____ Age:_____ Gender:_____ Marital Status:_____

Cell Phone:_____ Home Phone:_____

Email:_____

Occupation:_____ Employer:_____

Parent/Guardian (required if client under 18 years old) or **Emergency Contact**

Name:_____ Relationship:_____

Address:_____City, State, Zip:_____

Cell Phone:_____ Work Phone:_____

Client Questionnaire

Physician:_____

How did you hear about us?:_____

What is the primary issue that brings you in today?:_____

_____

Do you have additional issues that result in pain &/or activity limitations? If so, what are they?: _____

_____

When did your symptoms begin?:_____

How would you rate your pain over the last two days on a 0-10 scale (0 = no pain, 10 = worst possible pain)?: at present:_____ at worst:_____ at best:_____

What activities increase you pain?:_____

_____

What activities ease your pain?:_____

What activities are you currently limited with or missing out on because of your pain? List your top 3:_____

_____

What are your goals for PT?:_____

_____

List any tests (X-ray, MRI, blood work) that have been performed & the results: _____

_____

_____

Have you had any other treatments for you current condition? (PT, Chiropractic, Massage, Acupuncture) If so, what & was it effective?:_____

_____

Please list all medical conditions, including previous injuries & surgeries (include dates), &/or health concerns:_____

_____

_____

_____

_____

Do you have a recent history of any of these symptoms? (check all that apply):
Changes in bowel/bladder:____ Persistent joint pain:____ Unexplained weight loss/gain:____ Irritable bowel:____ Vertigo/lightheadedness/dizziness: ____ Nausea/Vomiting:____ Weakness/Fatigue:____ Difficulty Sleeping:____ Shortness of breath:____ Recurring Headaches:_____ Dental braces/splint: ____ Teeth grinding/clenching:____ Jaw popping/clicking:____ Fever/Chills/Sweats:____ Changes in appetite:____
For Women Only: Please list number of: pregnancies:____ children:____
Please list any pertinent information about pregnancies, complications with delivery, menstrual problems:_____

_____

_____

Office Policies & Procedures

Welcome & thank you for choosing Hartnett Physical Therapy!

Delaware's Direct Access law allows clients to be evaluated & treated by a PT for 30 days before needing a physician prescription. It is your responsibility to have a current prescription if you need physical therapy beyond 30 days of the initial evaluation. Your PT will fax a medical referral form to be signed by your physician upon your request.

Cancellation Policy
If you are unable to keep an appointment, please give us 24 hours advanced notice, otherwise you will be charged in full for the time that was reserved for you. You may cancel or reschedule your appointment by calling Hartnett Physical Therapy and leaving a message. If you are late for an appointment, you will be seen for the remainder of your reserved time, but responsible for the full session rate. Extenuating circumstances and special situations will be reviewed on an individual basis per the discretion of Hartnett Physical Therapy.

Consent to Treatment
Hartnett Physical Therapy is a hands-on Physical Therapy clinic. Forms of deep tissue massage, therapeutic exercise, neuromuscular re-education, joint manipulation, taping & other treatment modalities may be used.

Some of these treatments may cause bruising & soreness which may a few days. Symptoms may also change & move to other parts of the body. This is not unusual & is rarely a concern; however, please ask your PT if you have any concerns or questions.

The number of treatments needed & recovery time can vary widely due to many contributing factors such as the severity of the injury, duration of current symptoms, the age of the patient, etc.

I have read & fully understand the above statements. I understand the nature of the treatments at Hartnett Physical Therapy, LLC & I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe & effective recovery.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate in all physical therapy procedures, and comply with the established plan of care. I do hereby agree and give my consent for Hartnett Physical Therapy, LLC to furnish care and treatment that is considered necessary and proper in diagnosing and treating my physical condition. I verify that I have read and understand the cancellation/no show policy.

**Signature of client/legal guardian: _____Date: _____

Payment Agreement

Out-of-Network Policy: Hartnett Physical Therapy is a fee-for-service clinic. This means that Hartnett Physical Therapy is not "in-network" with any private health plans. Payment is due at the time of service & we will not bill your insurance company.

We accept cash, checks, credit cards, flexible spending, &/or health savings accounts .

We can, upon request, provide receipts with diagnosis & treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a medicare beneficiary (see Medicare Policy below).

Medicare Policy: If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has burdensome technical & administrative requirements that must be met for services to be reimbursed. We believe those requirements take unnecessary time away from the services we provide. Since the documentation & administrative processing of our services are not designed to meet Medicare's covered benefit requirements & we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider.

We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider.

By choosing to receive our services after being fully informed of these facts, you are agreeing, of your own free will, that you do not want Medicare involved in payment for your physical therapy services at Hartnett Physical Therapy. You agree to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider.

You also understand that since we are not enrolled Medicare providers & our documentation & administrative processes do not meet the technical requirements for Medicare to cover the services we provide, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstances, submit our claims, invoices, receipts, statements, or treatment notes to Medicare, a Medicare Advantage Plan, or to any primary-payer private insurance for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

Privacy Rights: You have a right to privacy under the Health Insurance Portability & Accountability Act (HIPAA) that includes restricting disclosure of your records & claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy & we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain & sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

Testimonial Approval: Hartnett Physical Therapy has permission to publish & share my testimonial: YES ___ or NO ____

I have read, understood & agreed to the above written statements & payment terms.

**Signature of client/legal guardian: _____Date: _____

Hartnett Physical Therapy
Communication Approval Form

We strive to give you the best client care possible. By signing below, it gives Hartnett Physical Therapy permission to contact you through cell phone text or email to answer questions & to give you better client service. By choosing to use the convenience of email & text to communicate, you understand & agree to the following: The use of email & text may pose risks to the confidentiality of your health information. The internet is an open network & provides no inherent protection for confidential information, & you accept those risks.

I, _____ give Hartnett Physical Therapy permission to contact me via cell phone & email.