Tidal Sports Rehab & Recovery, LLC

First Name _____ Date of injury/onset _____ Todays Date _____

Last Name _____ Date of Birth _____ Age _____

Social Security: _____-_____-_____ Sex: M F Marital Status: S M D W

Address _____

City _____ State _____ Zip _____

Employer: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Email address: _____

Injury Area: _____

Referring Physician: _____Phone ( ) _____-_____

Emergency Contact _____Phone: ( ) _____-_____

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

How did you hear about Tidal Sports Rehab & Recovery, LLC? _____

Please Initial after reading statements:

1. Consent to Treatment: I consent to rehabilitation and related services at Tidal Sports Rehab & Recovery, LLC. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

2. Treatment of Minor: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

3. Liability: I know and agree that Tidal Sports Rehab & Recovery, LLC is not responsible for loss or damage to personal valuables. _____

4. Authorization of Payment: I hereby assign all benefits directly to Tidal Sports Rehab & Recovery, LLC and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment.

_____

Patient Signature: _____Date: _____

Tidal Sports Rehab & Recovery, LLC

Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical report.

Name:_____ D.O.B.:____/____/_____

Referring Physician:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Date of Last General Health Check-up:____/____/____ Occupation:_____

Hospitalizations (Dates & Reasons):_____

Operations (Dates & Reasons):_____

Have you had Surgery for this Injury? Yes No Type of Surgery/Dates:_____

Pain (please draw a vertical line where you would rate your pain intensity): 0----------5----------10

No Pain Maximum Pain Tolerable

My pain can be described as: (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Current Medications: _____

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode? If yes, please specify.

	Yes	No		Yes	No
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you now have, or have you ever had, any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Heart Surgery	___	___	Weight Loss/Energy Loss	___	___
Blood Clot/Emboli	___	___	Hernia	___	___
Stroke/TIA	___	___	Epilepsy/Seizures	___	___
Allergies	___	___	Thyroid Trouble/Goiter	___	___
Pins or Metal Implants	___	___	Incontinence	___	___
Joint Replacement (any joint)	___	___	Bowel or Bladder Problems	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Infectious Diseases	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulty	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Do you smoke?	___	___	Multiple Sclerosis/Parkinson's	___	___
Latex Sensitivity/Allergy	___	___	Are you pregnant?	___	___

Family History: (Please circle all that apply to any member of your immediate family)

Diabetes Heart Disease Arthritis Adverse Reaction to Anesthesia

Patient/Guardian Signature:_____ Date:_____/_____/_____

PT Initials:_____ Date:_____/_____/_____

Tidal Sports Rehab & Recovery, LLC

Patient Responsibility and Policy Form

Private Self-Pay Patients:

1. Payments are due at the time of service (each session).
2. Patients should schedule follow-up appointments every 30 days with their Physician.
3. There will be a full session fee for any cancellation made less than 24 hours prior to your appointment time.
4. The treating therapist has the discretion not to treat patients that are more than 15 minutes late for their scheduled appointment.
5. Patients are encouraged to schedule appointments 2-3 weeks in advance. (We cannot guarantee your regularly scheduled appointment times.)
6. Authorization may be required for those seeking reimbursement from insurance carrier..
7. It is the patient's responsibility to know his/her insurance plan if they wish to submit for reimbursement from their carrier. If a referral is needed, the patient should have it upon their appointment time.

Patient Signature:_____ Date:____/____/____

Tidal Sports Rehab & Recovery, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Tidal Sports & Rehab & Recovery, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Tidal Sports Rehab & Recovery, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tidal Sports Rehab & Recovery, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Ashley O'Rourke, PT, DPT, ATC, LAT
138 Long Cove Ln
Mooresville, NC 28117
(910) 546-5917

With this consent, Tidal Sports Rehab & Recovery, LLC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Tidal Sports Rehab & Recovery, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Tidal Sports Rehab & Recovery, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Tidal Sports Rehab & Recovery, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Tidal Sports Rehab & Recovery, LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Tidal Sports Rehab & Recovery, LLC may decline to provide treatment to me.

Signature:_____ Date ___/___/___ Patient's Name (print):_____

Relationship to Patient:_____Name of Legal Guardian, if applicable (print):_____

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REHAB & RECOVERY

Acknowledgement of Privacy Practices

The Notice of Privacy Practices was offered to me and I have been provided an opportunity to review it.

I am aware that I am entitled to a copy of this Notice and that I have the opportunity to review it at any time, upon my request.

Name:_____ Date of Birth:____/____/____

Signature:_____ Date____/____/____

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REHAB & RECOVERY

Consent to Treat

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, any discomfort or risk that may arise, as well as, alternatives to the proposed treatment and the risk and consequences of no treatment.

Tidal Sports Rehab & Recovery LLC is a hands-on Physical Therapy practice. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of soft tissue mobilization, therapeutic exercise programs, neuromuscular re-education, as well as, other treatment modalities may be used. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 6-72 hours. Your therapist will review your plan of care & discuss these treatment options with you in order for you to provide specific consent.

Symptoms may also change and/or move to other parts of the body. This is not unusual and is rarely a concern; however, please speak to your treatment provider if you have any questions or concerns. The number of treatments needed and recovery time can vary greatly dependent on the age of the injury, the number of times injured, the age of the patient and many other contributing factors.

I acknowledge that all, or a portion of, my treatment may take place in an open and/or non-private setting, such as the gym, where third parties not employed by or affiliated with the clinic may be present. I am aware of, and consent to, the fact that these third parties may overhear some of my protected health information during the course of care and/or observe my course of treatment. Should I need to speak with my treatment provider in total privacy, I understand that my treatment provider will furnish a room for these conversations.

I acknowledge that at any time and for any reason, the physical therapist, Tidal Sports Rehab & Recover LLC, or myself may terminate treatment, whether it be rehabilitation or preventative care.

I consent to rehabilitation and related services at Tidal sports Rehab & Recovery LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature.

-I have read, agree with, and fully understand the above statements.
-I understand the nature of the treatments at Tidal Sports Rehab & Recovery LLC.
-I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

- I authorize Tidal Sports Rehab & Recovery LLC to release all medical information and/or records to my requesting insurance company and/or referring physician if needed or in the event of an emergency.

I have read, agree with, and fully understand the above statements. I consent to treatment.

_____	_____	_____	_____
Patient Name (Printed)	*Date*	*Guardian Name, if applicable (Printed)*	*Date*
_____	_____	_____	_____
Patient Signature	*Date*	*Signature of Guardian (if patient is under 18)*	*Date*