WELCOME TO GUIDRY PHYSICAL THERAPY!

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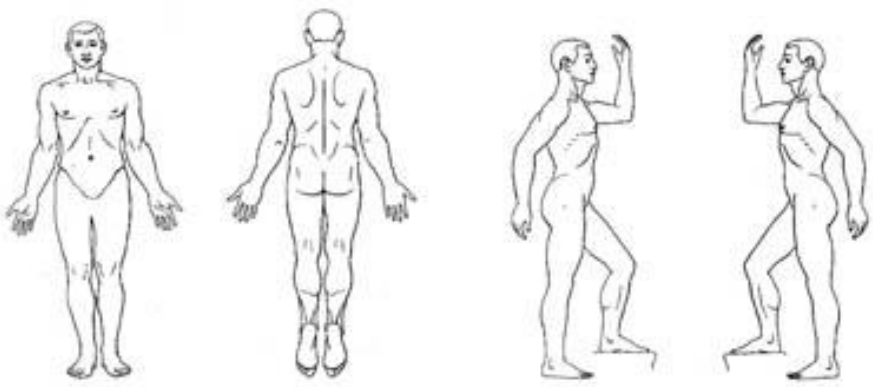
YOUR BASIC BIOGRAPHICAL INFORMATION

Name:	**HOW CAN WE CONTACT YOU?** Phone number: ( ) - OK to leave voicemail? ☐*Yes.* ☐*No.* Email address: OK to send you emails? ☐*Yes.* ☐*No.*
Mailing address:	
Sex: **Relationship status:** **Do you have insurance**? ☐*Yes.* ☐*No.* ***Please bring insurance card to your first visit.***	**WHO IS YOUR EMERGENCY CONTACT?** *Name:* *Phone number:* *Relationship:*
Date of birth: / / **Social Security Number:** - -	**WHO IS YOUR PRIMARY CARE DOCTOR?** *Name:* *City/state:*

YOUR VISIT TO GUIDRY PHYSICAL THERAPY

WHAT IS THE REASON FOR YOUR VISIT? **When did this problem start?** **Do you know why?**	**HOW DOES IT AFFECT YOUR LIFE?** *Does this condition affect your ability to:* Work or study? ☐*Yes.* ☐*No.* Enjoy your hobbies? ☐*Yes.* ☐*No.* Exercise? ☐*Yes.* ☐*No.* Care for yourself? ☐*Yes.* ☐*No.* Enjoy your relationships? ☐*Yes.* ☐*No.* Sleep? ☐*Yes.* ☐*No.*
What makes it feel better? **What makes it feel worse?**	**WHAT ARE YOUR SYMPTOMS?** ☐ constant, ☐ intermittent, ☐ infrequent, ☐ random, ☐ aching, ☐ stabbing, ☐ burning, ☐ worse at night, ☐ worse with activity, ☐ worse with rest, ☐ better in the morning, ☐ cramping, ☐ tearing sensation, ☐ dull,

Please circle, highlight, or describe where you are experiencing symptoms.



PHYSICAL THERAPY EXPECTATIONS.
Have you received physical therapy before?
☐Yes. ☐No.
If yes, why?

What are your expectations for our work together? How do you think our visits will be structured, and how do you expect to measure progress?

What prescription medications do you take?

Do you take any nutritional supplements or over-the-counter medications?

MENTAL HEALTH HISTORY.
Anxiety? ☐*Yes.* ☐*No.*
Depression? ☐*Yes.* ☐*No.*
Sleeplessness? ☐*Yes.* ☐*No.*
Self-harming behaviors? ☐*Yes.* ☐*No.*
Suicidal thoughts? ☐*Yes.* ☐*No.*
Other mental health symptoms:

Do you feel safe from violence, coercion, and abuse at home? ☐Yes. ☐No.
If not, we can direct you to social service agencies that can assist you. It's safe to tell us.

BRIEF HEALTH HISTORY.
Do you now or have you ever had:
Heart Disease ☐Yes. ☐No.
Endometriosis ☐Yes. ☐No.
Osteoporosis ☐Yes. ☐No.
Hypertension ☐Yes. ☐No.
Shortness of Breath ☐Yes. ☐No.

Cancer ☐Yes. ☐No.
Diabetes ☐Yes. ☐No.
Seizures ☐Yes. ☐No
Migraines ☐Yes. ☐No.
Neurological Disorder ☐Yes. ☐No.
Cardiological Disorder ☐Yes. ☐No
Bleeding Disorder ☐Yes. ☐No.
Asthma ☐Yes. ☐No
Bloody urine ☐Yes. ☐No
Bloody stool ☐Yes. ☐No
Blood clots ☐Yes. ☐No

SURGICAL HISTORY.
Have you had surgery before?
☐Yes. ☐No.
If yes, please provide the date(s) and reason(s):

Have you experienced any of the following symptoms recently?
☐ Unexplained weight loss ☐ Unrelenting Pain ☐ Dizziness or Fainting
☐ Bowel or Bladder Dysfunction ☐ Nausea/Vomiting ☐ Pain with eating or digestion
☐ Fatigue or malaise ☐ Significant changes in diet ☐ Change in or new activity
☐ Pain that does not vary with movement or changing positions ☐ Severe Weakness
Do you have any special needs that need to be considered during treatment?

PATIENT'S SIGNATURE

I have completed these forms to the best of my knowledge.

_____ _____
Signature Date

For clinic use. I reviewed these forms in-person with the patient and understand the reason for presentation in the clinic.
*Initial:*_____ *Date:*_____

GUIDRY PHYSICAL THERAPY SERVICES, LLC

Practice Policies Acknowledgment

Examination of Health Records & Privacy Policy

To receive a copy of your health records, please mail or provide your written request and authorization to the address listed on this form. Please note that copy, postage, shipping, scanning, and digital storage device fees may apply. I have read and understand this examination of healthcare records policy and agree to be bound by its terms.

Client initials: _____

The Clinic maintains strict privacy policies, and you have been given or offered a copy of its Notice of Privacy Practices.

Client initials: _____

Cancellation Policy

We understand that you are busy and that your schedule may change. However, we require a minimum of **24 hours notice** to cancel an appointment. Because appointments are in high demand, if you cancel in less than 24 hours, you may be subject to our cancellation policy of **$20.00**, payable at your next visit. Medicare/private insurances will not cover the cancellation charges.

We deliver the highest caliber physical therapy through our one on one visits with a physical therapist. To ensure that we can continue to provide you the best therapy possible, it is important that you attend all of your sessions as they are scheduled. A missed appointment with little or no notice takes away the opportunity for another patient to receive the care that they need as well. It is important to your progress that you are committed to your plan of care that is agreed upon between you and your therapist. If there are issues to sticking to this plan of care we ask that you discuss this with your therapist so that you can make necessary changes that work for you and your schedule.

I have read and understand this cancellation policy and agree to be bound by its terms.

***Client initials:* _____**

Insurance Billing & Self-Payment for Services

If we are in-network for your health plan, we will bill your health insurance company directly for our services. Verifying your insurance coverage and benefits is *your* responsibility but we will do this prior to your first visit as a courtesy to you. If we are out-of-network with your plan but you have out-of-network health insurance coverage, upon your request, we will provide the documentation necessary so that you may submit a claim to your insurer. You are responsible for paying any amount that your insurance company does not pay, which may be 100% of our fees.

I have read and understand this self-pay services policy and agree to be bound by its terms.

***Client initials:* _____**

Indemnification & Assumption of Risk

As a condition of receiving services from Guidry Physical Therapy, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses, including reasonable attorney's fees, relating to its services to you, except to the extent that such a claim is caused by our gross negligence or willful misconduct or is otherwise prohibited by law. Furthermore, you agree to assume all risk of property damage, injury, and/or death associated with the services that we provide to you. The terms of indemnification and assumption of risk shall survive the expiration of this agreement.

Client initials: _____

Treatment of Minors

If you are under the age of 18, your parent or guardian must consent to our services.

I_____, am the legal parent or guardian of _____, and I am authorized to make health care decisions on behalf of_____. Therefore, as parent/guardian I acknowledges the risks, benefits, and alternatives of services have been explained to both me and _____in the informed consent section of this form.

After careful review of this entire form, I,_____, hereby agree on behalf of _____ and myself to be bound by it and hereby authorize the services described herein to be provided to _____in my absence.

_____ _____

Parent/guardian Signature Date

Informed Consent for Physical Therapy Services

I, _____, acknowledge that Guidry Physical Therapy Services, LLC, a Louisiana limited liability company, its owners, agents, or employees ("Guidry Physical Therapy") will provide the following physical therapy services ("PT Services"):

I further acknowledge that:

- These PT Services and their material risks and benefits have been explained to me;
- These PT Services may not have the result that I expect, and I have been informed as to other possible services that may provide me a benefit;
- PT Services are not an exact science, and that I have not been given any guarantees about the result;
- I have had ample opportunity and time to discuss my concerns with Guidry Physical Therapy, and all my questions have been answered to my satisfaction.

By signing below, I acknowledge that I understand this policy and hereby provide my informed consent to receive PT Services as described above. The laws of the state of Louisiana, without giving effect to its principles of conflicts of law, govern all adversarial proceedings arising out of this agreement.

_____ _____

Date Patient Name