G3 Physical Therapy, LLC
225 Allegheny Street, Suite 103
Hollidaysburg, PA 16648
Phone: (814) 317-5270
Fax: (814) 317-5842

Informed Consent Authorization

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by G3 Physical Therapy, LLC. 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, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to G3 Physical Therapy, LLC for services rendered. G3 Physical Therapy, LLC will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

I may elect to pay out of pocket for physical therapy services. For patients without insurance or for those who elect to pay out of pocket, a discounted “cash rate” of $120 for the initial evaluation and $65 for follow-up appointments will apply, unless otherwise agreed upon. Payment will be due at the time of service.

Patient Information Consent Form (HIPAA)

I have read and fully understand G3 Physical Therapy, LLC’s Notice of Information Practices. I understand that G3 Physical Therapy, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations.

I also understand that G3 Physical Therapy, LLC will consider requests for restrictions on a case-by-case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in G3 Physical Therapy, LLC’s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point G3 Physical Therapy, LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Cancellation Policy

In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24- hour notice so that G3 Physical Therapy can offer my appointment to patients waiting on the standby list. If I fail to give 24-hour notice of a cancellation, I understand that I may be subject to a $50 missed appointment fee.

Designated Individuals Authorization

I, ____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print “none” below.

Authorized Designees:

Name: ____Relationship: ________________________

Name: ____Relationship: ________________________

I have read and understand the above consents, assignment of benefits, release of information, and designated individual’s authorization.

Print Patient Name: ____

Guardian Name (if applicable): ____

Patient or Guardian Signature ____Date_______________

Verified DL/ Photo ID ☐ Insurance Card ☐

Intake Completed by:	Date	Date Eval Scheduled

Patient Information

Last Name	First Name	Middle Initial

Address	City	State	Zip Code

Home Phone	Mobile Phone	Email

Date of Birth	SSN	Sex	Marital Status
		☐ Female ☐ Male	☐ Single ☐ Married ☐ Other

Physician Information

Referring Physician	Practice Name	Script Date
Primary Care Physician	**Practice Name**	**Phone**

Address	City	State	Zip Code

Emergency Contact

Contact Name	Phone	Relationship

Employer Information

Employer	Employment Status ☐ FT ☐ PT ☐ Retired ☐ Student

Address	City	State	Zip Code

Work Phone	Occupation

Primary Insurance	Secondary Insurance
Insurance Plan	**Insurance Plan**
Policy ID #	**Policy ID #**
Group #	**Group #**
Insurance Phone #	**Insurance Phone #**

Medical History Form

Patient Name: _________________________________ Patient ID: ______________ Date of Injury: _______________

Diagnosis as stated to you by your physician: ____

How did this injury/ exacerbation occur? ____

Have you been hospitalized for the present condition? Yes □ No □ If Yes, date: ________________________________

Have you had surgery for the present condition? Yes □ No □ If Yes, date: __________ Surgery type:________________

Have you had any falls this past year? Yes □ No □ If Yes, how many? ____

Have you ever received previous treatment for this condition? Yes □ No □ If Yes, date: __________________________

Summarize: ____

Have you ever had any of the following? EMG □ CT Scan □ Myelogram □ MRI □ X-RAY □

Have you ever, or are you presently being treated for any of these conditions?

Condition	Yes	No
Acquired Respiratory Distress Syndrome	Yes □	No □
Angina	Yes □	No □
Anxiety or Panic Disorders	Yes □	No □
Arthritis (RA, OA)	Yes □	No □
Chronic Obstructive Pulmonary Disease (COPD)	Yes □	No □
Congestive Heart Failure	Yes □	No □
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	Yes □	No □
Depression	Yes □	No □
Diabetes	Yes □	No □
Emphysema	Yes □	No □
Hearing Impairment	Yes □	No □
Heart Attack	Yes □	No □
Multiple Sclerosis	Yes □	No □
Osteoporosis	Yes □	No □
Parkinson's Disease	Yes □	No □
Peripheral Vascular Disease	Yes □	No □
Stroke or TIA	Yes □	No □
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	Yes □	No □
Visual Impairment (cataracts, glaucoma, macular, degeneration)	Yes □	No □

Condition	Yes	No
Allergies	Yes □	No □
Headaches	Yes □	No □
Back Injury	Yes □	No □
Bleeding Disorders	Yes □	No □
Bowel/ Bladder Abnormalities	Yes □	No □
Cancer	Yes □	No □
Dizzy or Fainting Spells	Yes □	No □
Epilepsy or Seizure Disorders	Yes □	No □
Hepatitis A, B, C	Yes □	No □
Hernia	Yes □	No □
High Blood Pressure	Yes □	No □
HIV/AIDS	Yes □	No □
Hypoglycemia	Yes □	No □
Immunosuppressant Condition or Medication	Yes □	No □
Kidney Problems	Yes □	No □
Liver/ Gallbladder Problems	Yes □	No □
Metal Implants	Yes □	No □
Nausea/ Vomiting	Yes □	No □
Pacemaker	Yes □	No □
Defibrillator	Yes □	No □
Pregnancy	Yes □	No □
Ringing in Your Ears	Yes □	No □
Sexual Dysfunction	Yes □	No □
Skin Abnormalities	Yes □	No □
Smoking	Yes □	No □
Tuberculosis	Yes □	No □
Other:		

List of Current Medications: