DRAGONFLY

PHYSICAL THERAPY

Patient Name: ____ DOB: __________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been ☐offered and declined or ☐given the Notice of Privacy Practices for Dragonfly Therapy. I recognize that I must give my written authorization to Dragonfly Therapy to release any of my protected healthcare information in instances beyond purposes for treatment, payment, certain healthcare operations, or in instances required or permitted by law.

Patient Signature/
Authorized Representative: _____________________________ Date: __________________

INFORMED CONSENT FOR CARE AND TREATMENT

Physical therapy (PT) involves the use of many different types of treatment and evaluations.

Dragonfly Therapy and its employees, volunteers, and students use a variety of procedures and modalities to help improve an individual's function. As with all forms of medical treatment, there are benefits and risks involved with PT.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict a patient's response to therapy. We are not able to guarantee what a patient's reaction to a particular treatment may be, nor can we guarantee that treatment will improve the condition addressed by therapy. There are risks of pain, injury, or aggravation to previously existing conditions.

You have the right to ask your PT what type of treatment is planned for you. You may discuss the potential risks and benefits of treatment and the outcomes of choosing not to receive treatment. You have the right to stop treatment at any time.

I acknowledge that my treatment program has been explained and all of my questions have been answered to my satisfaction. I understand the risks associated with treatment, and I wish to proceed.

Patient Signature/
Authorized Representative: _____________________________ Date: __________________

Consent to Automated Calls or Text Usage for Appointment Reminders

I consent to receive ☐ Text Reminders ☐ Automated Call reminders from the practice to the following phone number _______________________. I understand that this request will apply to all future appointment reminders unless I request a change in writing. I understand that while Dragonfly Therapy does not charge for this service, standard text messaging rates may apply as provided in your wireless plan (contact your carrier).

Patient Signature/
Authorized Representative: _____________________________ Date: __________________

DRAGONFLY
PHYSICAL THERAPY

Patient Name: ____ DOB: __________________

FINANCIAL POLICY STATEMENT

1) It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy.
2) If any payments of medical benefits are made directly to you for services rendered by Dragonfly Therapy, you must promptly remit such payment directly to Dragonfly Therapy.
3) If your account balance is not paid in full within 60 days of receiving your first patient statement, the entire account balance shall be subject to a monthly finance charge of 1.00% (Annual percentage rate 12.00%) and monthly costs of rebilling/account maintenance charges of $8.00. These rates and charges are subject to change upon 30-day written notice in advance of changes.
4) If any account balance should be placed with a collection agency or attorney for collection the patient agrees to pay all costs of collection, including court costs, collection agency fees and/or reasonable attorney fees.
5) If you are a Workers' Compensation patient, Section IV does not apply to you. Be advised however, that you may be responsible for your charges if your Workers' Compensation claim is denied.
6) I authorize that the payments from my insurance benefits are made directly to Dragonfly Therapy for any services that are reimbursable by my insurance company, if I have one.
7) Dragonfly Therapy has a returned check fee of $40.

PAYMENT AUTHORIZATION
(Initials required for all 4 statements)

________ **Initials**	**Guarantee of Payment** I understand that all payments designated as the "patient's responsibility" such as co-insurances and deductibles are due and payable at the time of service **OR** statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.
________ **Initials**	**Home Health** I certify that I am not currently receiving Home Health services. I understand that it is the Home Health agency's responsibility to provide therapy services. I understand that if I am currently receiving or will receive Home Health services, it is my responsibility to pay for therapy services provided by Dragonfly Therapy.
________ **Initials**	**Cancellations** All cancellations must be made 1 business day prior to scheduled appointments. Any appointments cancelled with less than 24 hours' notice **may be** subject to a $25 fee.
________ **Initials**	**No Shows** Failing to arrive for your scheduled appointment without prior notice will result in a charge of $50.

I have read the above information and it has been explained to me. I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient or Authorized Representative: ____ Date: _____________
(Signature)

DRAGONFLY

PHYSICAL THERAPY

Authorization for Release of Information

Authorization is not required for disclosing information related to treatment, payment, healthcare operations, or when disclosure is required by law. You may refuse to sign this authorization.

Patient Name: ____ **DOB:** ___________________

I only authorize the release of information to the individuals/entities identified below by name, and I allow these individuals to release information to Dragonfly Therapy:

Name/Facility: __________________________________ Relationship: ___________________________

Name/Facility: __________________________________ Relationship: ___________________________

Name/Facility: __________________________________ Relationship: ___________________________

The purpose for the requested information: ☐ Personal ☐ Legal ☐ Continuity of Care

☐ Other: Please specify _________________________________

Please choose one:

☐ I DO ☐ I DO NOT wish to review identifiable health information from the above facility prior to release. If I choose to review the information, I will present to the facility named above to review the records prior to release.

Dragonfly Therapy will only disclose the protected health information authorized by the patient. I authorize the release of **all information UNLESS described or marked below:**

☐Physical Therapy Notes	☐ Mental Health/Psychotherapy Records
☐Functional Assessments	☐AIDS/HIV Testing
☐Evaluation/Examination	☐ Chemical/Alcohol Dependency
☐Past Medical History	☐ Other:____________________________________

Check only one, unless otherwise revoked, this authorization will expire on the following date:

☐Disclose my information indefinitely (for as long as Dragonfly Therapy has custody of my files)

☐____/____/______ (please specify date you would like this authorization to expire)

By signing I acknowledge:

*I understand that this authorization does not expire unless I have indicated an expiration date above.
*I understand that I can refuse to give authorization without fear of retaliation or treatment limitations.
*I understand that if I give authorization, I may revoke it at any time by notifying Dragonfly Therapy in writing.
*I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession.
*I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it.
*Dragonfly Therapy will not be compensated for using or releasing my PHI (apart from related treatment or payment procedures) unless specific authorization is obtained from the patient following full disclosure of purpose and intent.

______________________________ ______________________________ ________________

Signature of Patient or Representative **Relationship (if signed by representative)** **Date**

Past Medical History

Patient Name: ____ **DOB:** __________________

Primary care Provider:___________________________**Other Specialist (s):**________________________

In the last 30 days have you received services from a hospital, nursing home or home health agency?
YES / NO If yes, who:___________________________**When:**___________________________________

What are we seeing you for?____

Have you seen any other medical providers for this issue? ☐**YES** ☐**NO**
____ **PCP** ____ **PT** ____ **OT** ____ **Chiropractor** ____ **Other:**_____________________________________
When:______________________________**Where:**____

Have you had images for this issue or a related problem? ☐**YES** ☐**NO**
____ **X-Ray** ____ **CT Scan** ____ **MRI** ____ **Ultrasound**
When:______________________________**Where:**____

Surgical History:
Heart Surgery (pace maker, stents, etc.):_______________________________**Date:**_________________

Surgery:	Date:	Surgeon:
Surgery:____________________________	Date:______________	Surgeon:___________________

On a scale of 0-10, please rank your pain. Zero being pain free and 10 the worst pain

Pain:______**Location:**____**Start date:**__________________

Have have you fallen in the last 12 months? ☐**YES** ☐**NO How did you fall (slip, trip, etc.)?**__________________
Did the fall result in injury? ☐**YES** ☐**NO**
Medication List: ☐**YES** ☐**NO**
Please list your medication below if list is not provided:

1.	2.	3.

YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Epilepsy / Other seizure disorder
☐	☐	Heart Disease / Heart attack	☐	☐	Problem w/eyes (glasses / contacts)
☐	☐	Allergies (latex / tape)	☐	☐	Problem w/ears (hearing aid?)
☐	☐	Stroke	☐	☐	Lung problems (COPD / Asthma)
☐	☐	Diabetes	☐	☐	Bleeding Disorders (blood thinner)
☐	☐	Cancer	☐	☐	Arthritis
☐	☐	Osteoporosis	☐	☐	Dizziness / Vertigo (current / past)
☐	☐	Metal Implants (including IUD's, bullets, staples, plates, etc.)			

Signature:__________________________________ **Therapist Signature:**__________________________

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