

Joint Effort Physical Therapy
1880 Airport Rd Unit C
Hot Springs, AR 71913-2117
P(501)781-2701
F(501)781-2702



Medical Information Release Form (HIPAA Release Form)

Release of Information

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

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to: **(Please include NAME AND NUMBER BELOW)**

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is NOT to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.*

Messages

Preferred method of Contact: ☐ Home Phone: _____ ☐ Mobile Phone: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

Appointment Reminders

☐ Mobile Phone: ☐ via text message ☐ via voice message

☐ Home Phone via voice message

☐ Email

☐ Please do not send appointment reminders

Signature of Patient or Legal Gardian

Date

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JOINT EFFORT

PHYSICAL THERAPY

Past Medical History

Name: _____

Date: ____/____/____

Do you OR have you ever been told that you have any of the following:

	(CIRCLE ONE)	IF YES, PLEASE EXPLAIN
PACEMAKER	Yes No	
DIABETES	Yes No	
HIGH BLOOD PRESSURE	Yes No	
HEART DISEASE/HEART ATTACK	Yes No	
ALLERGIES	Yes No	
ASTHMA	Yes No	
ANY METAL IMPLANTS	Yes No	
PREGNANT OR POSSIBLY PREGNANT	Yes No	
USE TOBACCO PRODUCTS	Yes No	
ANY UNEXPLAINED WEIGHT LOSS/GAIN	Yes No	

Please list any current medications you are taking: _____

Please list any surgeries you have had in the last 5-10yrs: _____

Personal Goals and/or Concerns regarding your current condition: _____

Pain Rating: On a scale of **0** (NO PAIN) to **10** (EXTEREMLY SEVERE PAIN), Please rate your pain below.

Currently /10 When the pain is at its WORST /10 When the pain is at its BEST /10

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Patient Name (Printed): _____

FINANCIAL RESPONSIBILITY: I agree to pay my rehabilitation therapy provider (“Joint Effort Physical Therapy”) all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney’s fees.

Signature of Patient or Legal Guardian: _____ Date: ____/____/____

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian: _____ Date: ____/____/____

Patient Consent for Photograph Use:

Photographs may be taken of patients during physical therapy. These photos are used on the Joint Effort Physical Therapy website, social media and/or posted within the clinic. I give consent to Joint Effort Physical Therapy to use photographs of me and/or my child (or person for whom I am legal guardian). I understand the image may be seen by members of the general public that visit the clinic, website, or social media post by Joint Effort Physical Therapy. I understand that it is possible that someone may recognize me. By consenting to these photographs, I understand that I will not receive payment from any party.

Signature of Patient or Legal Guardian: _____ Date: ____/____/____

OR

If you wish to **decline** Photograph Use, please sign and date below:

Signature of Patient or Legal Guardian: _____ Date: ____/____/____