



## **Thin Air Physical Therapy**

Patient's Name \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ SSNumber \_\_\_\_\_

Marital Status \_\_\_\_\_ Email \_\_\_\_\_

Phone Number \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Guarantor (If you are under 26 years of age, list responsible party)

Guarantor Name \_\_\_\_\_

Guarantor DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Guarantor Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Guarantor Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Employer Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Insurance Carrier/Work Comp \_\_\_\_\_

ID# \_\_\_\_\_ Group ID # \_\_\_\_\_

Policy holder name \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_

ID# \_\_\_\_\_ Group ID # \_\_\_\_\_

Policy holder name \_\_\_\_\_ DOB \_\_\_\_\_



**Do you exercise regularly?**    Yes    No

**Do you use nicotine products?**    Yes    No

**Do you drink alcohol?**    Yes    No    **If yes, how many drinks/day?** \_\_\_\_\_

**What is your primary complaint that brings you to physical therapy?**

---

---

**Please describe your primary symptom (i.e. sharp/stabbing/burning, mild/moderate/severe)** \_\_\_\_\_

---

---

**Have you received any other treatment for this condition?** \_\_\_\_\_

---

**When did these symptoms start?** \_\_\_\_\_

**Please List Surgical History:** \_\_\_\_\_

---

---

---

---

**Do you have any of the following conditions?**

**Arthritis**

**AIDS/HIV**

**Cancer**

**Diabetes**

**Asthma**

**Heart Disease**

**Lung Disease**

**Epilepsy/seizures**

**Stroke**

**High/low blood pressure**

**Thyroid Disorder**

**Liver Disease**

**Depression**

**Anxiety**

**Blood clots**

**Other:** \_\_\_\_\_



**Current Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature/Responsible Party Signature Date \_\_\_\_\_

### **Consent to Photograph**

I, \_\_\_\_\_, hereby (circle one) **AUTHORIZE/ DO NOT**  
Thin Air Physical Therapy to utilize photographic material of myself for social  
media/marketing purposes.

The photographic material may be kept on file for future social  
media/marketing purposes, and may be used in the future by Thin Air  
Physical Therapy for additional marketing reasons.

\_\_\_\_\_  
Patient Signature/Responsible Party Signature Date \_\_\_\_\_



## **Receipt of Notice of Privacy Practices Form**

Effective July 21, 2021, I, \_\_\_\_\_, hereby acknowledge receipt of Thin Air Physical Therapy's Notice of Privacy Practices. Thin Air Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment, and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Thin Air Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Thin Air Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Thin Air Physical Therapy.

\_\_\_\_\_  
Patient Signature/Responsible Party Signature

\_\_\_\_\_  
Date

If you are not the patient, please specify your relationship to the patient

\_\_\_\_\_

\_\_\_\_\_  
Print name



## **INFORMED CONSENT FOR PHYSICAL THERAPY**

I understand that I am a patient of Thin Air Physical Therapy and their independent physical therapy practitioners. My care is the exclusive responsibility of the practitioners of Thin Air Physical Therapy.

**Cooperation with treatment:** In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

**No warranty:** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

**Informed consent for treatment:** The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

**Potential benefits:** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

**Payment:** I understand that I am responsible for any charges not covered by insurance. I have read the above information and I consent to physical therapy evaluation and treatment.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature/Responsible Party Signature

\_\_\_\_\_  
Date



## **Delinquent Payment Policy**

I acknowledge that I am receiving physical therapy services and agree to pay for any and all balances accrued for the subsequent treatment provided. I understand that if timely payments are not received after second and final notices have been sent, delinquent balances will be immediately sent to collections. I further agree to pay all costs, expenses and attorney's fees should my account be turned over to an attorney or collection agency and regardless of whether or not a claim is filed. In the event a lawsuit or claim is filed, the court or presiding tribunal shall award the prevailing party all reasonable attorney's fees, legal expenses, collection costs and court costs incurred in connection with such legal proceeding (together with pre-litigation fees and expenses), and including any appellate action or arbitration proceedings.

---

Patient Name

Date

---

Patient Signature/Responsible Party Signature



## **Assignment of Benefits**

RELEASE OF INFORMATION: I authorize Thin Air Physical Therapy, PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that COPAYMENT IS DUE AT THE TIME OF SERVICE (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Thin Air Physical Therapy, PLLC if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature/Responsible Party Signature

\_\_\_\_\_  
Date