Action Potential
One on One Physical Therapy

_____ _____
Client Name Date of Birth

_____ _____
Referring Physician Primary Care Physician

_____ Identified Gender: Male / Female / Other
Email

Past Medical History:

□Alzheimer's	□Fibromyalgia	□Parkinson's
□Cardiovascular Disease	□Fracture	□Rheumatoid Arthritis
□Coronary Artery Bypass	□High Blood Pressure	□Brain Injury
□Heart Attack	□History of Cancer	□COPD/Emphysema
□Pacemaker	□Huntington's	□Asthma
□Cauda Equina Syndrome	□Immunosuppression	□Osteoporosis
□Stroke/TIA	□Lupus	□Cataracts
□Current Infection	□Muscular Dystrophy	□Amputation
□Diabetes Mellitus Type I	□Obesity	□Anxiety
□Diabetes Mellitus Type II	□Osteoarthritis	□Depression
□Diabetic Neuropathy	□Pelvic Pain/Incontinence	

□Other: _____

□Surgeries: _____

□Recent Falls: YES NO Explain:_____

At the present time would you say that your health is:
□excellent □very good □fair □poor

Please rate your current pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

therapist initial: _____ date: _____

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Medication List: Please list all prescription and over the counter medications, vitamins, supplements. Include dose, frequency, and route
If you already have a current list, we are happy to make a photocopy

Name	Dose	Frequency	Route (oral, injection, etc.)

therapist initial: _____ date: _____

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Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Action Potential, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Attn: Compliance Officer, Action Potential, 1786 Wilmington Pike, Suite 200A, Glen Mills, PA, 19342.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

   _____

5. I authorize the Practice, to disclose my health information that is directly related to my current treatment to the individual(s) listed below:

   _____ _____
   Name of Individual(s) Relationship to Client

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Client or Representative Date

_____ _____
Client's Printed Name Client's Date of Birth

_____ _____
Printed Name of Representative (if applicable) Relationship to Client

Scheduling Availability: Please cross out any times that you are unavailable for appointments

Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening

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Client Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Action Potential, LLC, is pleased to be your physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. We encourage you to call your primary and secondary insurance providers to verify and responsibility you may have in receiving physical therapy services at our location. You are responsible to notify Action Potential, LLC of any changes to your insurance plan.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. These payments are due at the time of service. You are also responsible for any amount not covered by your insurance carrier. If your insurance carrier (including Workers Compensation and Motor Vehicle) denies any part of your claim, or if you elect to continue services past your approved period, you will be responsible for your balance in full. Credit card on file will be used to charge outstanding statement balances when unpaid 30 days post issue.

I have read the above policy regarding my financial responsibility to Action Potential, LLC and I authorize my insurer to pay the full and entire amount of the bill for the above-mentioned patient. I will assume responsibility for any remaining balance and permit this amount to be charged to my card on file.

_____ **(initial) Your co-payment amount:** _____

Office Policies

_____**(initial)** There will be a **$25.00** penalty assessed for any returned check.

_____**(initial)** We request 24 business hours notice for all cancellations due to our one to one policy. Cancellations made in less than requested time allotment will result in a **$50.00** charge to your card on file.

Consent to Treatment

_____**(initial)** I hereby consent to evaluation and treatment (onsite and virtual) by the therapists at Action Potential, LLC.

_____**(initial)** I consent that information regarding my care may be communicated via voicemail/text and/or email.

_____**(initial)** I acknowledge that if I elect to pursue a virtual visit that it will not be provided through a HIPAA secure portal.

_____**(initial)** I consent to being photographed or video taped for the purpose of patient education, instruction, and development of a home exercise program. I am aware that media specific to my plan of care will be placed in my medical record as protected health information and only disclosed to me. Media will not be disclosed further without my consent.

Client Signature: _____ **Date:** _____

Client Representative: _____ **Date:** _____
(If patient is a minor, or if authorized by patient)