Performance Driven Physical Therapy

Acceptance of Financial Responsibility:
I understand that I am responsible for all medical expenses for service rendered by Angie Koonin, DPT, LAT, ATC.

Consent for Treatment:
I hereby authorize and give my consent to Angie Koonin to provide me/my child or dependent with physical therapy services including trigger point dry needling if desired.

Information Release:
I authorize Angie Koonin to provide information to my physician or attorney concerning my injury and treatment by any means necessary.

I have read the above policies and agree to them.

_____ _____ _____
Patient Signature Parent/Guardian Signature Date

Notice of Privacy Practices

Date: _____ Name: _____
Print Name

I reviewed the available copy of the Notice of Privacy Practices.

Signature: _____
Patient or Guardian

_____ _____ _____
Witness Signature Date

Permission to Communicate with Caregivers Form
So that I may serve you better, you have the option of providing me with a list of caregivers with whom I may discuss your health information. You are required to provide a list and/or to sign this form.

I _____ give consent to Angie Koonin to share health information with the people listed below who assist with my care. I understand that this lets Angie Koonin share certain health information. If I do not want to share certain information, I have listed it below.

Name	**Phone Number**	**Relationship**
_____	_____	_____
_____	_____	_____

_____ _____ _____
Patient/Patient Representative Signature Date/Time Print Name

_____
Witness Date/Time

Performance Driven Physical Therapy
Patient Information Form

Full Name _____
Last First Middle

Address _____
Street City State Zip

Phone _____
Home Cell Work

Email _____ DOB _____ Sex _____

Referring Physician _____

Emergency Contact _____
Name Phone Relationship

If patient is a minor _____
Guardian's Name __ Address Phone

Why are you here today?_____

If having pain, please circle on scale 0-10: 0 1 2 3 4 5 6 7 8 9 10
(No pain) (Excruciating)

Surgeries and dates: _____

X-rays: Y / N **MRI:** Y / N **CT Scan:** Y / N Other: _____

Your overall health is: □ Excellent □ Good □ Fair □ Poor

Important Medical History: _____

Are you Pregnant: Y / N Do you have a pacemaker: Y / N

Current Medications: _____
_____

Allergies: Y / N _____ Do you have any LATEX sensitivity: Y / N

Social History:
Living Situation: □ Alone □ Family □ Friends □ Other _____
Have you ever been afraid of, hurt or forced by anyone against your will? Y / N
Do you have transportation concerns? Y / N
Do you have needs for food, shelter and medication that are unmet? Y / N
Has a major life change/event occurred that may affect your therapy? Y / N
Have you fallen in the past year? Y / N
Functional status: Please list any activities that you are having trouble doing due to your present injury.
_____

If patient agrees and wants his/her photo on the wall, I give permission to allow this. _____
If patient agrees and wants his/her photo on Instagram, I give permission to post. _____
I give permission for Angie Koonin to text or email me/child updates/HEP/appointments. _____

This information was reviewed by: _____ Date: _____