Welcome to Battle Born Health

Name: ____

DoB: ___________________ **Phone:** ___________________________

Email: ____

Thank you for choosing Battle Born Health as your provider for rehabilitation, wellness, and fitness services. Our entire staff is committed to serving you and making your rehabilitation experience enjoyable and successful. Please take a few minutes to read this information so that you can become familiar with our practice.

Battle Born Health is committed to providing the highest quality physical therapy services available in Northern Nevada. We will consistently provide individualized rehabilitation programs focused on the recovery of the body as a whole. The Doctors of Physical Therapy at Battle Born Health blend compassion, education, and years of successful experiences in to every treatment session, so you are able achieve your highest goals.

This page must be read and signed before we can see you for physical therapy services.

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.

Explanation of potential risks, potential benefits, and alternatives to treatment:

- Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my 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.
- Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist at Battle Born Health cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

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

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print Name ____ Date__________________

(If patient is a minor, this and all following signatures must be that of a legal guardian)

Patient or Guardian Signature____

Physical Therapy Goals and Medical History

Patient Name____

Type of Injury/Condition ____

Onset/Injury Date ____

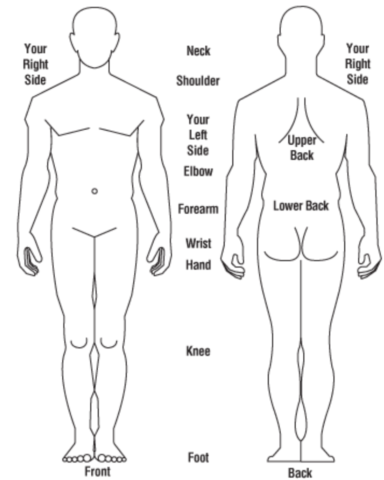
Type of Surgery (If Applicable) __________________________ Surgery Date________________________

- **What are your goals for physical therapy**? ____
- **Please describe your physical limitations**____
  as a result of this injury or condition ____
- **Please circle any activities or movements that aggravate your symptoms**: sitting standing bending walking twisting driving reaching overhead dressing sleeping other_____________
- **Please describe any previous injury or injuries that could affect care:**
- **Have you had any of the following diagnostic tests in relationship to this injury?**
  (Circle all that apply) X-Ray CT Scan MRI Doppler Ultrasound
- **Which of the following describes your pain?** Sharp Aching Burning Tingling Numbness
  Other: ____________________________________

Please Rate Your Pain (0 = None, 1=Minimal, 10 = Severe)

Please mark the location of your symptom(s)

Present	0 1 2 3 4 5 6 7 8 9 10
At its worst:	0 1 2 3 4 5 6 7 8 9 10
At its best:	0 1 2 3 4 5 6 7 8 9 10



- **Please list all current medications and supplements**
  ____
  ____
  ____

Have you recently noticed any of the following? (Circle all that apply)

▪ Breathing Difficulty ▪ Change in Vision ▪ Fever/Chills/Sweats
▪ Insomnia ▪ Nausea/Vomiting ▪ Pain at Night ▪ Pregnancy
▪ Weakness ▪ Weight Loss/Gain ▪ Fatigue

Do you have now or have you ever had any of the following?

▪ Allergies/Skin Sensitivity ▪ Asthma/Breathing Problems ▪ Autoimmune Deficiency ▪ Cancer ▪ Circulation Problems ▪ Diabetes ▪ Fractures ▪ Heart Problems ▪ High Blood Pressure ▪ Indigestion/Heartburn ▪ Kidney Disease ▪ Leg/Ankle Swelling ▪ Loss of Consciousness ▪ Lung Disease ▪ Metal Implant ▪ Motor Vehicle Accident ▪ Multiple Sclerosis ▪ Osteoporosis/Osteopenia ▪ Sprains/Strains ▪ Stroke ▪ Surgeries ▪ Thyroid Problems ▪ Urinary Problems/ Infections

Please explain and give approximate dates for any conditions marked above:

____
____
____
____

Patient Essential Information

Full Name (as it appears on insurance card)____

Preferred Name/Nickname______________________ Date of Birth___________________ Age_________

Best Contact Phone # __________________________ Secondary Phone #______________________________

Gender_____ Email Address ____

Street Address__________________________ City_________________ State____________ Zip_____________

Emergency Contact Name______________________________ Emergency Contact Phone # _______________

Relationship______________________________________

How did you find out about Battle Born Health? (Please Circle One) ▪ Yelp ▪ Physician ▪ Facebook ▪ Twitter ▪ Word of Mouth ▪ Battle Born Health Website ▪ Other (Please Specify): __________________________

Name of Primary Care Physician (If Applicable) _________________________Phone ___________________________

Battle Born Health Essential Info

The following pages will orient you to payment information, and office policies that will help make your treatment experience at Battle Born Health as seamless as possible. Your signature will be required to establish that you've read and understand everything explained.

Many people seek physical therapy for declining function, postsurgical issues, acute injury/trauma, chronic disease or condition, deconditioning, complex pain, stress overload, repetitive overuse injuries and more. Physical therapy treatment involves mobility planning/skilled interventions, and is based on movement impairment models. Goals are established at the time of examination, will relate to improving one's physical functioning, and will be modified based on limitations, real-life considerations, and individual progress.

Contact Info

- Address: 690 W. 2nd Street, Suite 101, Reno NV 89503
- Phone: 775.747.2278 Fax: 775.747.2279

Appointments

- Office hours are by appointment only.
- We respect your personal schedules and make every effort to accommodate your scheduling needs.
- To change appointments, we require 24 hours' notice. (Please see cancellation policy.)

Attire

- Please wear or bring with you loose, comfortable clothing to your visits.
- Clothing that can be easily moved aside to access the affected area or injury, and clothing that you can move freely (Think loose workout clothes.)

Health Care Information Privacy Policy

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

The law requires us to:
- Keep your medical information private.
- Give you notice describing our legal duties and privacy practices.
- Notify you of any changes in our privacy practices.

This form is to inform you on the various ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

I have read, understand, and agree to use of my information as listed above.

Print Name ____ Date__________________

Patient or Guardian Signature____

Battle Born Health Office Policies

Financial

- It is our policy in this office to maintain your account on a current basis.
- Charges for services are due at the time the service is provided.
- Your balance must be paid in full on or before the 1st day of the following month, any unpaid balance will be considered past due on the 5th of the month.
- An interest charge of 1% per month may be applied to all past due balances.

Voluntary Termination of Care

- If you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

Patient Responsibilities

Please initial all sections to indicate understanding of responsibilities of physical therapy.

It is the patients' responsibility to:

- Wear loose, comfortable clothing to allow freedom of movement during sessions. **Initials**_______
- It is the patient's responsibility to pay for balances due in a timely manner for services rendered. **Initials**_______

Battle Born Health Responsibilities:
It is Battle Born Health's responsibility to:

- Provide quality Physical Therapy and Wellness services.
- Answer all patient questions about payment to the best of our ability.

By signing below, I acknowledge that I have read, understand, and agree to all policies and responsibilities set forth in the pages entitled "Battle Born Health's Essential Information and Office Policies."

By signing below, you acknowledge that you have read the above information.

Print Name ____ Date__________________

Patient or Guardian Signature____

Commitment to Physical Therapy

Late/No show and Rescheduling Policy

Your adherence to the recommended schedule of treatments is a vital component of your progress with our services; therefore, we feel to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Cancellations

With the exception of serious emergencies your recovery depends upon attending all your appointments.

- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible. Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care.

Late Appointments/No Shows

- If you are less than 15 minutes late and have contacted Battle Born Health to warn us that you'll be late, you may complete the remaining time scheduled for your session, knowing that you will not receive a full session.
- If you are more than 15 minutes late and have not contacted Battle Born Health, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a fee equal to the value of one session.
- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you a no-show fee equal to the value of one session.
- Reminder Calls: While we offer automated reminder calls as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the no-show fee equal to the value of one session.
- If you need to cancel or reschedule a session, you are more than welcome to do so, please provide us 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel less than 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a cancellation fee.
- Cancellation and No-Show fees are not billable to any form of insurance. ▪To resume treatment following a late cancel, late reschedule, or no-show, the fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to discontinue services.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation. By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Print Name ____ Date__________________

Patient or Guardian Signature____