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

All pages must be read and signed before we can treat you for therapy services.

Informed consent for treatment:

▪The term "informed consent" means that the potential risks, benefits, and alternatives of therapy treatment will be explained to me prior to treatment. **Initials_____**

▪ The therapist provides a wide range of services and I understand that I will receive information during my visit concerning the treatment and options available for my condition. **Initials_____**

Explanation of potential risks

▪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. **Initials_____**

No Warranty

▪I understand that my therapist at Battle Born Health cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me recommendations regarding potential results of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. **Initials_____**

Physical Therapy Goals and Medical History

Patient Name____

Type of Injury/Condition ____________________________________

Onset/Injury Date ____

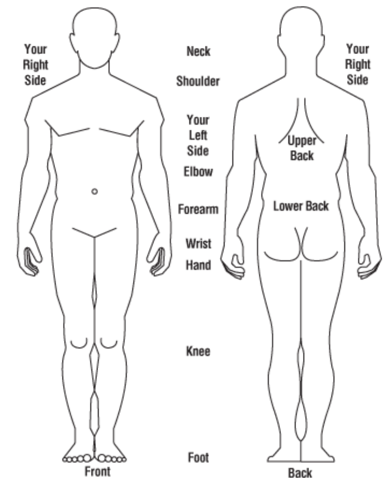
Type of Surgery (If Applicable) ___________________ Surgery Date_________________

- **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)

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 mark the location of your symptom(s)



- **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____

Insurance Company/ Member number____

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.

Contact Info

- Address: 690 W. 2nd Street, Suite 101, Reno NV 89503
- Phone: 775.747.2278 Fax: 775.747.2279
- Email: Danielle@battlebornhealth.com or Admin@battlebornhealth.com

Financial Policies

- 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.
- Visit Packages are to provide a discounted rate for our cash pay patients. To be eligible for this discounted rate the package is paid in full and up-front. All visits must be completed within an 18-month period.
- **No Refunds** will be given for unused visits. **Initials**_____

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

Patient Responsibilities

Please initial all sections to indicate understanding of responsibilities of Therapy Services.

It is the patients' responsibility to:

▪Wear loose clothing that allow access to affected region and movement during sessions (think shorts and tank tops). **Initials**_______

Cancellations

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

- Please notify us 24 hours prior to your appointment, 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 visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. **Initials**_______

Late Appointments/No Shows

- If you are less than 15 minutes late and have contacted Battle Born Health to notify 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 $75.00 cancellation fee
- 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 of $75.00
- Reminder Calls: While we offer automated reminder calls/ texts 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 of $75.00.
- 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 $75 cancellation fee.
- Cancellation and No-Show fees are not billable to insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the fee will be due and payable before your next visit. If you refuse to pay the fee, we reserve the right to discontinue services.

We are excited to be working with you at Battle Born Health. 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____