

IWPT Patient Intake Form

Please fill out this form to provide us with your initial patient information.

* Indicates required question

1. **Today's date(date that you are completing this form)** *

Example: January 7, 2019

2. **Full Name: First, M.I., Last** *

3. **Date of Birth** *

Example: January 7, 2019

4. **Email** *

5. **Phone # (best number to reach you at)** *

6. **Preferred Pronouns** *

Mark only one oval.

- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ Other

7. **Primary Care Provider and Phone #** *

8. **Medication List** *

Please provide a list of all medications you are currently taking. If there aren't any medications please enter "NA" or "none"

9. **Emergency Contact: Name and Phone#** *

10. **Patient Information Consent (HIPAA)** *

Integrated Wellness and Physical Therapy PC is required by law to maintain the privacy and security of your protected

health information. A Notice of Privacy Practices (NPP) is provided to all patients and explains how your Protected Health Information (PHI) may be used or shared, your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI, your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintaining the privacy of your PHI.

I acknowledge that I have been given a copy of the "Notice of Privacy Practices" or an opportunity to read the practice's Notice of Privacy Practices that explains when, where, and why my Protected Health Information (PHI) may be used or shared.

Signature _____

11. **Consent to Treat** *

I acknowledge that my physical therapist (hereinafter "PT") has informed me of my diagnosis, prognosis and the potential risks and benefits of all recommended interventions in my proposed plan of care and I have been given an opportunity to have all my questions answered. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read this consent form, understand the benefits and risks involved in physical therapy, and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Signature _____

12. **Consent for E-mail/Text Communication and Appointment Reminders** *

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voicemail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

Mark only one oval.

- ☐ I do NOT consent to any email, voicemail, or texting communication (choosing this option will mean I can not see you)
- ☐ I consent to Email, voicemail, and texting communication

13. **Direct Physical Therapy Treatment Services** *

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the Podiatric Medical Board of California and acting within their scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person or telehealth patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Signature _____

14. **Notice to Consumers** *

I have been provided a copy of the CA Notice to Consumers form number NTC12-01. (see below)

Please sign at the bottom of this page

DID YOU KNOW?

The Physical Therapy Board of California
licenses and regulates your Physical Therapist and
Physical Therapist Assistant.

**A Physical Therapy Aide, while regulated by the Board, is not licensed.*

Visit the Board's website at www.ptbc.ca.gov for
information on:

- **Verifying a license**
- **What to expect when you receive care**
- **Your rights as a patient**
- **How to file a complaint**

Board Contact Information

2005 Evergreen Street, Suite 2600
Sacramento, CA 95815
1-800-832-2251



PHYSICAL THERAPY
BOARD OF CALIFORNIA



Title 16, California Code of Regulations, §1398.15 requires all licensed physical therapists to provide this notice.

Form NTC 12-01, August 2, 2012

Signature _____