**HEALTH HISTORY QUESTIONNARE**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All of the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

**Do you smoke?** ⁭ No ⁭ Occasionally Socially Daily Heavily

**Do you drink alcohol? ⁭** No ⁭ Occasionally ⁭ Socially ⁭ Daily ⁭ Heavily

**Do you recreational drugs?** ⁭ No ⁭ Occasionally Socially ⁭ Daily ⁭ Heavily

**Do you exercise?** ⁭ No ⁭ Yes

If yes, how many days per week? \_\_\_\_\_\_\_\_\_\_\_\_\_minutes/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe exercise or activity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Status:** ⁭ Circle one

Unemployed Working Full-time ⁭ Working light duty Student

Homemaker ⁭ Working Part-time ⁭ Disabled ⁭ Retired

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please rate your health**: Excellent Good Fair Poor Don’t Know

**Major life Changes (past year):** Death in Family New Job Divorce Move

None Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle if anyone in your family has or had any of the following:**

Heart disease High blood pressure ⁭ Cancer ⁭ Psychological problems Lung disease ⁭

Diabetes ⁭ Arthritis ⁭ Stroke Osteoporosis ⁭ Allergies ⁭ Hearing Loss ⁭

Vertigo Balance problems ⁭ Migraines No history Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any conditions from your health history:**

* Diabetes
* Kidney Disease
* Parkinson’s Disease
* AIDS
* Emphysema
* Liver Disease
* Prostate Disease
* Allergies
* Epilepsy/Seizures
* Low blood pressure
* Skin disorders
* Asthma
* Fibromyalgia
* Lung disorder
* Sleep disorders
* Arthritis
* Glaucoma
* Lyme’s Disease
* Stroke
* Blood disorders
* Heart attack
* Macular Degeneration
* Thyroid disorders
* Broken bones
* Heart Disease
* Meniere’s Disease
* Ulcers (stomach)
* Chronic Fatigue Syndrome
* Hepatitis
* Migraines
* Repeated infections
* Circulation problems
* Head Injury
* Muscular Dystrophy
* Reoccurring Vertigo
* Cancer
* High blood pressure
* Multiple Sclerosis
* Cystic Fibrosis
* High cholesterol
* Osteoporosis
* Depression
* Genetic Disease
* Pacemaker

**Within the last year, have you had any of the following? (check all that apply):**

* + No symptoms
	+ Headaches
	+ Syncope (passing out)
	+ Bowel problems
	+ Hearing loss
	+ Tinnitus (noises in your ear)
	+ Chest pain
	+ Heart palpitations
	+ Tremors
	+ Cough (persistent)
	+ Joint pain or swelling
	+ Urinary problems
	+ Concentration problems
	+ Loss of appetite
	+ Vertigo
	+ Difficulty driving
	+ Loss of balance
	+ Vision problems
	+ Difficulty walking
	+ Motion sickness
	+ Weakness in arms/legs
	+ Difficulty sleeping
	+ Nausea/Vomiting
	+ Weight gain (unexplained)
	+ Dizziness ⁭
	+ Numbness in arms/legs
	+ Weight loss (unexplained)
	+ Excessive sweating
	+ Pain at night
	+ Dizziness with loud noises
	+ Fatigue
	+ Pressure in your ears
	+ Dizziness with physical exertion
	+ Foggy headedness
	+ Shortness of breath
	+ Other:

**Drug allergies:** ⁭ No ⁭ Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⁭**Airborne pathogens:** ⁭ No ⁭ Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you receiving any treatment for allergies?** If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Within the last year, have you had any of the following Diagnostic Testing (check all that apply):**

* ⁭No diagnostic testing
* Bronchoscopy
* Hearing tests
* Pulmonary Function Test
* Angiogram
* CT scan
* Mammogram
* Speech/Language evaluation
* Arthroscopy
* Ultrasound
* MRI
* Stool test
* Biopsy
* Echocardiogram
* Pap smear
* Stress test
* Blood test
* EEG
* EMG/Nerve conduction
* Urine test
* Bone scan
* EKG
* ENG
* X-Ray
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For women only:**

Pelvic Inflammatory Disease? ⁭ No ⁭ Yes Trouble with period? ⁭ No ⁭ Yes

Complicated pregnancies? ⁭ No ⁭ Yes Currently pregnant? ⁭ No ⁭ Yes

Endometriosis? ⁭ No ⁭ Yes Hormonal changes? No Yes

Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgeries you have had and, if known, include dates:**

* No surgeries to date

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

**FALL RISK ASSESSMENT TOOL**

* Have you fallen before or have you been injured because of a fall?
* Do you feel unsteady on your feet or shuffle when you walk?
* Have you stopped doing daily activities or avoided exercise for fear of falling?
* Do you feel weaker than you used to or have less strength in your arms and legs?
* Are you taking sedatives, anti-depressants, anti-parkinson’s, diuretics, or anti-hypertensives?
* Do you have trouble getting out of a chair?
* Has your eyesight diminished, have trouble seeing depth, or decreased night vision?
* Do you feel dizzy when you stand up or change positions?
* Have you experienced hearing loss?
* Do you have any foot problems or foot pain that cause you to adjust your steps?

**Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use “*✔*” to indicate your answer)*

1. **Little interest or pleasure in doing things**

Not at all Several Days More than half the days Nearly Every Day

1. **Feeling down, depressed, or hopeless**

Not at all Several Days More than half the days Nearly Every Day

1. **Trouble falling or staying asleep, or sleeping too much**

Not at all Several Days More than half the days Nearly Every Day

1. **Feeling tired or having little energy**

Not at all Several Days More than half the days Nearly Every Day

1. **Poor appetite or overeating**

Not at all Several Days More than half the days Nearly Every Day

1. **Feeling bad about yourself- or that you are a failure, have let yourself or your family down**

Not at all Several Days More than half the days Nearly Every Day

1. **Trouble concentrating on things, such as reading the newspaper or watching television**

Not at all Several Days More than half the days Nearly Every Day

1. **Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual**

Not at all Several Days More than half the days Nearly Every Day

1. **Thoughts that you would be better off dead or of hurting yourself in some way**

Not at all Several Days More than half the days Nearly Every Day

 **10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all Somewhat difficult Very difficult Extremely Difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

**Payment Agreement**

Thank you for choosing Fort Worth Balance Therapy Center, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

* You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
* Payment is expected at time of service unless you have made other payment arrangements with us.
* **Out-of-Network Policy.** (Commercial Insurance - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
* **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services are not designed to meet Medicare’s covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our services do not meet the technical requirements for Medicare covered benefits, our services are *not* subject to Medicare’s maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
	+ **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
* **Wellness & Fitness Services.** Commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
* **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare, unless we have agreed to accept assignment and await payment from your health insurance insurer (we do not accept assignment from Medicare). If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
* **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

**I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.**

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient and/or Guardian**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Provider Representative**

A photocopy of this agreement is to be considered valid, the same as if it was the original.

**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.

Patient’s Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Communication:** Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Fort Worth Balance Therapy Center, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Fort Worth Balance Therapy Center, LLC will not be 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.

I do not consent to any voicemail, email or texting communication. I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):

o Email o Text o voicemail

I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (circle all that you consent to):

**o Email  o Text  o voicemail**

Patent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Notice of Privacy Practices Acknowledgement**

**I acknowledge that I have been given a copy of or an opportunity to read the practice’s Notice of Privacy Practices.**

**(X)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s or Guardian’s Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**

**HIPAA Authorization for Use and Disclosure of PHI for**

**Marketing and/or Promotional Purposes**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Fort Worth Balance Therapy Center, LLC, and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes:

1. Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on Fort Worth Balance Therapy Center’s website and social media sites.
2. Use in news releases or stories, including television, newspaper, or radio broadcasts.
3. Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites.

I further authorize Fort Worth Balance Therapy Center, LLC to use and/or disclose the following information personal information in conjunction with the use/disclosure of my photographs, videos and/or audio recordings:

* My name
* My demographic information
* Information about my diagnosis, physical therapy problems, basic treatment information, or other personal information necessary to accomplish the purpose of the marketing/promotional effort, except as specifically described as follows (please describe if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I provide my authorization knowing that:

* The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
* Signing this authorization is voluntary. I have the right to refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.
1. • I understand that I can revoke or cancel this authorization at any time by sending written notice to:

Fort Worth Balance Therapy Center

Attn: Valerie Johnson, PT, DPT

5332 El Campo Avenue

Fort Worth, Texas 76107

* If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.
* I am entitled to receive a copy of this Authorization upon request.

Unless I revoke this authorization, it will expire 30 months from the date signed below.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative (Print name, if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representatives Relationship to Patient (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approved by the Texas Board of Physical Therapy Examiners**

Physical Therapy Treatment without Referral Disclosure Please read carefully and acknowledge below: I understand that physical therapy treatment without a referral will be based on the physical therapist’s examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction. I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis. I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process. I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging. I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process. I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained. I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner. I acknowledge that I have received the above disclosure.

**Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature** of Patient or Legal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Signed by Legal Representative, Print Name and Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_