New Patient Consent Forms

Please fill out the details. * Denotes a required field.

Please circle Agree or Disagree on each statement.

Financial Agreement

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Quad C Physical Therapy or Dr. Kearstin Cooley, DPT. all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges NOT paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Agree Disagree

Informed Consent

I hereby indicate my wish to be a participant in the rehabilitation program by Quad C Physical Therapy. I understand that the purpose of this program is to enhance my recovery from an injury or illness. Furthermore, I understand that there exists the possibility of some risks associated with the services that are intended to improve my well-being and functionality. I have been informed of methods of treatment that will be administered and understand what is required of me as a patient. I verify that my participation is fully voluntary and that no coercion of any sort has been used to obtain any participation and that I may withdraw from treatment at any time.

Agree Disagree

HIPAA Compliance Patient Consent Form

By singing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive. By signing this form I understand that: protected health information may be disclosed or used for treatment, payment, or healthcare operation. The practice reserves the right to change the privacy policy as allowed by the law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will the cease, the practice may condition receipt of treatment upon execution of this consent.

- I agree that Quad C Physical Therapy, LLC may leave me a message via email, phone call, and/or text to confirm upcoming appointments.
- I agree that Quad C Physical Therapy, LLC may discuss my medical condition with the following family members or friend:
- _____

Agree Disagree

I agree to terms listed and all information provided is accurate.

Patient or Patient's Guardian, signature.

X_____

QUAD C PHYSICAL THERAPY

Personal & Contact Information

Please fill in any of the missing information below as well as correct any incorrect information.

Personal Details

First Name (Legal)	Last Name (Legal)	
Date of Birth	Male	Female

Contact Details

Address		
City	State	Zipcode
Phone	Mobile	Email
How did you hear about us?		

Please enter any Emergency Contact(s) for this case.

Name	Phone

Payment Details

Are you using insurance? YES NO

Is this a personal injury, auto accident, or workers comp related? YES NO

Please list all insurance OR guarantor information in boxes below:

Injury Details

Relevant Injury Dates
Onset of Symptoms
What date did you first experience symptoms related to your injury?
Date of Surgery
If you had surgery for this issue, what was the date of the most recent surgery?
Date of Initial Treatment
If you started treatment at another facility on an earlier date, please add that date here.
If there is anything you think we need to know, please include it below.
Previous history of symptoms YES NO

Height	Weight
What is the main reason you are seeking medical attention? What problem can we help you solve?	
Goal List: Check all that apply or add custom in text area below	

Return to Normal Mobility		Reduce pain to improve overall function	
Perform all Activities of Daily Living without pain		Walk long distances without pain	
Stand for prolonged period of time without pain		Sit for prolonged period of time without pain	
Perform flight of stairs without pain and good function		Sleep without disturbances or pain	
Dress independently without pain and improved function		Reduce dizziness	
Additional Goals			

Medical History

Have you ever suffered from or been told you have any of the following?

High blood pressure		Heart problems	
Lung problems		Liver problems	
Stroke		Head injury	
Multiple sclerosis		Thyroid problems	
Parkinson's disease		Blood disorders	
Diabetes		Low blood sugar	
Cancer		Arthritis	
Other orthopedic problems		Circulatory or vascular problems	
Broken bones (fractures)		Osteoporosis	
Chronic Pain		Ulcers/Stomach Problems	
Chronic Migraines		Denies Significant Health Problems	

Who have you seen for your condition before today?

Medical Doctor	
Massage Therapist	
Chiropractor	
Athletic Trainer	
Physical Therapist	
Acupuncturist	
Occupational Therapist	
Speech Therapist	

Please list any medications you are currently taking with the name, dosage, frequency, and the method that you take it.

Please list any known allergies that you have.