



Yes! Physical Therapy, LLC

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Feel Better - Be Better - Get to Yes!

<https://www.yespt.biz>

The Following Forms are Required Prior to Your First Visit or Physical Therapy Checkup.
Please Review and Sign them:

1. Consent to Treat / Financial Policy...(2 pages)
2. Intake Forms(3 pages)

You Can Bring Forms With You to Your Appointment
or Attach Them to Our Secure Contact Form.

If You Plan to Fill Out Forms in the Office, Please Plan to Arrive 15 Minutes Early.

Thank You.

You may also want to fill out the optional Media Release Form.

This will give Yes! the right to take photos/videos during treatment,
which can be used as a way to make your home exercises more effective.

Please Be Aware

If You Are Currently Involved in an Injury-Related Lawsuit, Yes!
Physical Therapy Will NOT be Able to Accept You as a Patient/Client.

If Medicare is Your Primary Insurance, Yes! PT Will NOT be Able to
Accept You as a Patient/Client.



CONSENT TO TREAT

I hereby authorize *Yes! Physical Therapy* and/or their designated agent, to perform the following procedures: outpatient physical therapy and rehabilitation services, which may consist of several different evaluation procedures and treatments, including manual therapy (joint and soft tissue mobilization and manipulation), exercise, and/or physical agents (heat, cold, ultrasound, electrical stimulation, etc.).

I consent to the performance of physical therapy and other rehabilitation services in addition to or different from those now contemplated, based on the recommendation of *Yes! Physical Therapy* and/or their designated representative, as may be determined during the course of treatment.

Any recommended services will be explained so that I understand the benefits, potential risks, and treatment alternatives.

I understand that I may refuse treatment at any time without penalty or prejudice.

Date: _____

X _____


Your signature

Please print your name legibly:

X _____

Signature of parent or legal guardian, if patient is a minor

Please print name legibly:

Please turn over to view and sign our Financial Policy 



FINANCIAL POLICY

Yes! Physical Therapy LLC, is committed to providing our clients with the best possible health care while minimizing administrative costs. Our financial policy reflects these aims.

- The current hourly rate for care is \$150, billed in 15 minute increments.
- An initial evaluation usually takes one hour. Typical treatments take 30 minutes. Evaluation and treatment times may be adjusted up or down at the discretion of Yes! Physical Therapy and/or their designated agent, in consultation with the client.
- Payment is due at the time of service.
- Payment for professional services can be made with cash, personal check or credit card.
- This practice does not accept any health insurance. If you receive care, you are responsible for payment, regardless of insurance status. It is the responsibility of the client to insure that any materials needed for insurance reimbursement, such as referrals or treatment authorizations, are obtained prior to the first visit. If you have questions, call our friendly staff at 410 531 2150. They'll be happy to help.
- Minors can only be treated with the consent of an accompanying adult. The accompanying adult (or guardian) is responsible for payment at the time of service.

CANCELLATION POLICY

Clients are expected to provide twenty four (24) hour notice for non-emergency appointment cancellations. A missed appointment with no prior notice will be charged at the then-current 30 minute rate increment.

If you are late to your appointment by 15 minutes or more, you may not be able to be seen. You should be prepared to reschedule.


Yes! Physical Therapy reserves the right to refuse treatment to any individual who has three (3) or more cancellations or no-shows in any 6 month period.

Date: _____ X _____
Client signature

Please print your name legibly: _____

X _____
Signature of parent or guardian, if patient is a minor

Please print name legibly: _____

Please turn over to view and sign our Consent Form. 



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For office use only
Patient ID

PATIENT INFORMATION*

Date: _____

First Name

Middle

Last Name

Gender: M F Date of Birth: _____

Occupation: _____ Referred by: _____

Contact Information (please check your preferred method of communication)

Home phone #

Office phone #

Mobile phone #

Email (please print legibly)

I hereby give permission to Yes! Physical Therapy to communicate with me via indicated means.

X _____
Your signature (your printed name is accepted as your signature)

Emergency Contact Information

Name: _____ Phone: _____
Please print legibly

Health Contact Information

Primary Care Physician Name

Phone

Fax

Other Care Provider Name

Phone

Fax

* The privacy of your personal information will be protected to the fullest extent allowed by law, in compliance with HIPAA regulations. For more information, see: <http://www.hhs.gov/ocr/privacy/index.html>

Please turn over and fill in information on the back





REVIEW OF SYSTEMS

Please check each answer below only if it applies to you.

GENERAL	
Recent Weight Loss	<input type="checkbox"/>
Fever	<input type="checkbox"/>
Chills	<input type="checkbox"/>
VISION	
Visual Changes	<input type="checkbox"/>
EARS, NOSE, THROAT	
Hearing Loss	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>
HEART	
Chest Pain or Pressure	<input type="checkbox"/>
Irregular Pulse or Palpitations	<input type="checkbox"/>
Loss of Energy	<input type="checkbox"/>
Swelling in Hands or Feet	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>
Thigh Cramps	<input type="checkbox"/>
LUNGS	
Cough	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
DIGESTIVE	
Stomach Pain	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>
URINARY	
Frequent Urination	<input type="checkbox"/>
Urgency	<input type="checkbox"/>
Leakage	<input type="checkbox"/>

MUSCULOSKELETAL	
Joint Pain or Swelling	<input type="checkbox"/>
Restricted Motion	<input type="checkbox"/>
Musculoskeletal Pain	<input type="checkbox"/>
SKIN	
Rashes	<input type="checkbox"/>
Sores	<input type="checkbox"/>
Blisters	<input type="checkbox"/>
Growths	<input type="checkbox"/>
NEUROLOGICAL	
Numbness or Tingling	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>
Burning	<input type="checkbox"/>
MENTAL HEALTH	
Nervousness or Anxiety	<input type="checkbox"/>
Depression	<input type="checkbox"/>
ENDOCRINE	
Heat or Cold Intolerance	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>
BLOOD / LYMPH	
Abnormal Bleeding	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>
IMMUNE	
Allergic Reaction	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>
ANYTHING UNUSUAL	<input type="checkbox"/>
If yes, please explain:	

Please Initial: _____

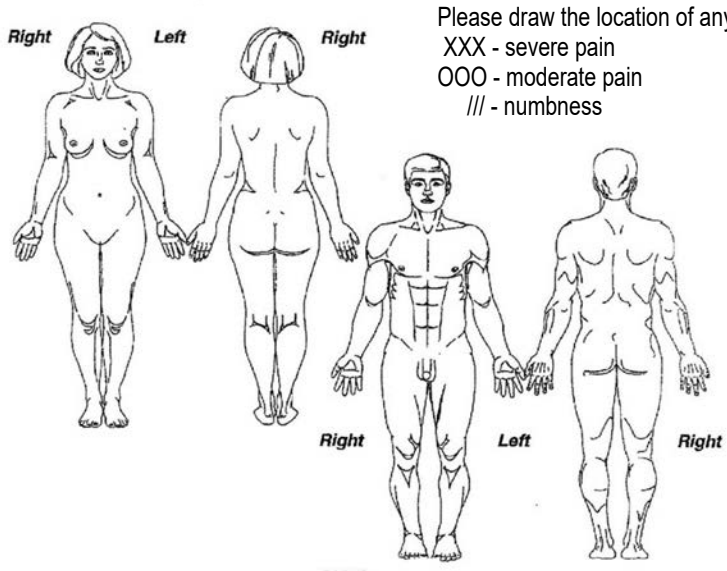
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PAIN / MEDICATIONS / HISTORY



Please draw the location of any pain:

XXX - severe pain

OOO - moderate pain

/// - numbness

Please initial here:



<input checked="" type="checkbox"/>	Condition (check if applicable)	Tell us about your medications. Please include any herbal/homeopathic medications (fish oil etc.):	Tell us about any surgery you had, and when. The exact date isn't necessary. A ballpark estimate is fine.
<input type="checkbox"/>	High blood pressure		
<input type="checkbox"/>	Heart problems		
<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	Fracture		
<input type="checkbox"/>	Breathing problems		
<input type="checkbox"/>	Rheumatoid disease		
<input type="checkbox"/>	Migraines		
<input type="checkbox"/>	Stroke / Neurologic problem		
<input type="checkbox"/>	Incontinence		
<input type="checkbox"/>	Anxiety / Depression		
<input type="checkbox"/>	Dizziness		
<input type="checkbox"/>	Previous Treatment, if any =>		
<input type="checkbox"/>	Other (please describe) =>		