New patient Consent form

Client Information:

First name _____

Middle initial _____

Last name

_____

- Date of Birth: (month/date/year)

_____/_____/_____

- Address:

_____

City _____. MARYLAND

ZIP CODE _____

- Phone Number:

(_____)_____-_____

- Email:

_____

- Emergency Contact Name and Phone:

Name:_____

Phone number:

(_____)_____-_____

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Introduction:
This Waiver and Consent Form is designed to inform you about the terms and conditions regarding your participation in virtual and/or in-person cash-based physical therapy and wellness services. By signing this document, you agree to the contents outlined in this form, including the payment rules and cancellation policy.

1. Acknowledgment of Services:
I understand that I am voluntarily seeking wellness and/or physical therapy services, which may include assessment, treatment, and education regarding my physical condition. I acknowledge that these services may be provided virtually (via telehealth platforms) or in-person at the designated facility.

2. Risks and Limitations:
I acknowledge that there are potential risks associated with virtual wellness/physical therapy consultations, including but not limited to:
- Technology failures such as loss of connectivity
- Inability to perform hands-on assessments
- Miscommunication regarding my condition and treatment

I understand that the effectiveness of the consultation may be limited compared to in-person visits.

2. Consent to Treatment:
I hereby consent to the provision of physical therapy services by Firstline Lymph and Pelvic Therapy LLC or their designated representatives, including but not limited to assessments, interventions, and telehealth consultations.
I confirm that I have had the opportunity to ask questions regarding the nature and purpose of virtual wellness consultation and/or physical therapy and have received satisfactory answers. I consent to receiving care via a virtual platform and in person.

3. Financial Responsibility
- The total cost of services rendered will be communicated at the time of booking.
- Payment is required within 24 hours of booking an appointment to secure your slot.
- Accepted payment methods include debit cards, credit cards, Zelle.
- Failure to make payment within the stipulated time may result in cancellation of the scheduled appointment.

4. Cancellation Policy
- To cancel or reschedule an appointment, patients must provide at least 24 hours' notice.
- Cancellations made less than 24 hours before the scheduled appointment may incur a cancellation fee of full charge.
- Payment methods accepted include cash, credit card, Zelle and other forms specified by the provider. I acknowledge that I will receive an invoice for the services rendered and confirm my payment method during the booking process.
- In cases of emergency or unforeseen circumstances, I should communicate with the provider as soon as possible to discuss the implications of my cancellation.
- All payments are non-refundable regardless of attendance or session completion.

5. Risks and Benefits:

I acknowledge that participation in physical therapy may involve certain risks, including but not limited to discomfort, temporary soreness, and in rare instances, infection or injury. I also understand the benefits associated with physical therapy, including increased mobility, decreased pain, and improved physical health.

6. HIPAA Compliance
- We are committed to maintaining the confidentiality of your health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- Your personal and medical information will be kept secure and will only be disclosed to authorized personnel involved in your care or as required by law.
- I consent to the use of my health information for the purposes of treatment, payment, and healthcare operations.
- By signing this form, you acknowledge receipt of the HIPAA Notice of Privacy Practices.

7. Release of Liability:
I hereby waive and release Firstline Lymph and Pelvic Therapy LLC, their employees, agents, volunteers, and representatives from any, and all liability for any injuries, losses, or damages that may occur as a result of my participation in physical therapy services, whether in-person or virtual.

8. Acknowledgment:
I have read this Waiver and Consent Form carefully, and I fully understand its contents. I am aware that this is a waiver of liability and a consent to treatment. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

Client/ Patient Signature:

_____

Date: _____

Note: If you are signing on behalf of a minor or individual unable to sign for themselves, please indicate your relationship to the individual:

Relationship:_____

Signature: _____

Date: _____

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General Health questionnaire:

New Client Intake Form
Firstline Lymph and Pelvic Therapy

Gender at birth: please check ✔️
Female __
Male __
Prefer not to say __

Employer/Occupation
_____

Medical History Questionnaire

1. In the past 3 months have you had or do you experience: (check all that apply)

___ Nausea/vomiting
___Changes in appetite
___Fever/chills/sweat
___Chest pain
___Changes in Bowel/bladder function
___Difficulty sleeping
___Blood in stool or urine
___Numbness in the inner thigh region
___Shortness of breath
___Vertigo or dizziness
___Unexplained weight loss
___Tiredness/fatigue
___Changes in your balance/falls
___Not Applicable (N/A)

2. Have you or any immediate family member ever been told you have: (check all that apply)

__Allergies/Asthma
__Recurrent headaches
__Bronchitis
__Kidney disease
__Ulcers
__Seizures

__Anemia
__Cancer
__Diabetes
__High blood pressure
__Heart disease
__Osteoporosis
__Rheumatoid arthritis
__Weakened immune system
__Not Applicable (N/A)

3. Do you have any heart disorder?
__ YES
__ NO

4. Do you have any kidney disorder?
__YES
__NO

5. Do you take any thyroid medications?
__YES
__NO

6. Do you have any current UTI or infection?
___ YES
___ NO
___ Not sure

7. HAVE YOU HAD ANY SURGERIES?
__Yes
__No

7-1. If you have had surgeries, please write them down.

_____

8. ARE YOU TAKING BLOOD THINNERS?
__Yes
__No

9. ARE YOU PREGNANT?
__Yes
__No
__Not sure
__N/A

10. Did you fall within the past 6 months?
___ YES (if so, how many? ___ times)
___ NO

11. Vitals
Weight _____ lbs
Height _____ ft ____in

11. Do you have any pain today?
___ YES
___ NO
If yes, what is your pain level(0-10) ? ___/10.

Where is your pain?

_____

What aggravates the pain?

_____

The END.
Please submit the form via email.
Info@selectfirstline.com
Please also complete and send the form for pelvic health and/or lymphedema. You can find it on our website(patient forms).
www.selectfirstline.com

Thank you for choosing Firstline Lymph and Pelvic Therapy.
Where Healing Comes First and You Come First.