jodi@foundationstherapypt.com
Phone: 316-833-7733 Fax: 316-804-8767
Practice Address: 2517 North Main Street North Newton, KS 67117
Mailing Address: 3231 South Hillside Road Newton, KS 67114

FOUNDATIONS THERAPY LLC

New Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Phone Numbers: home _____

work _____

cell _____

Insurance information:

Insured's Name: _____

Insured Address: _____

_____

Relationship to Client: self spouse child other

Primary Insurance Company: _____

ID#: _____ Group #: _____

Address: _____

Phone number: _____

Secondary Insurance Company: _____

ID#: _____ Group #: _____

Address: _____

Phone number: _____

Current Physician: _____

Authorization of Benefits:

I hereby authorize payment of benefits directly to Foundations Therapy LLC. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize Foundations Therapy to release any information acquired in the course of any examination or treatment necessary to establish a health insurance claim for payment.

Client signature: _____ Date: _____

Guardian Signature (if under 18yrs): _____ Date: _____

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Patient Information and Treatment Consent Form

I have read and fully understand Foundations Therapy LLC, Notice of Privacy Practices. I understand that Foundations Therapy LLC, may use or disclose my personal health information for the purposes of carrying out treatment, payment, or health care operations. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, or health care operations if I notify Foundations Therapy LLC.

I hereby consent to use and disclosure of my personal health information for purposes as noted in Foundations Therapy LLC Notice of Privacy Practices. I understand that I retain the right to revoke the consent by notifying Foundations Therapy LLC, in writing at any time.

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. I hereby voluntarily consent to physical therapy treatment.

Potential risks: You may experience lightheadedness, fatigue, shift in sleep state, bowel/bladder changes with the result of treatment techniques. If it does not subside in 24-48 hours, I agree to contact my physical therapist.

I, the patient, understand that in order to best treat my condition that manual therapy techniques may be performed on the anterior chest region *near* breast tissue, the anterior pelvic region *near* genital tissue and structures, and in the posterior and inferior gluteal region of sacrum, coccyx, and ischial tuberosities. At any time if I am uncomfortable with any treatment, I will immediately tell my therapist and I understand that I can decline any portion of the treatment.

I grant permission to all therapists I see at Foundations Therapy to us all of the techniques they know, including MNRI, RMTi, Touch for Health, Stress Indicator Point System, Myofascial release techniques, joint mobilizations, therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me until I am discharged from care.

Patient Name **(Date)**

Patient Signature (or Patient representative) **(Date)**