Smith Physical Therapy + Running Academy

SMITH PHYSICAL THERAPY AND RUNNING ACADEMY, LLC

PHYSICAL THERAPY PATIENT INFORMATION

DATE:		
NAME:		
DATE OF BIRTH:	**PHONE:**	
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
***E-MAIL:**		
HOW DID YOU HEAR ABOUT SMITH PHYSICAL THERAPY AND RUNNING ACADEMY?		
EMERGENCY CONTACT:	**PHONE:**	

REFERRING PHYSICIAN:		**PHONE:**	
PRIMARY PHYSICIAN:		**PHONE:**	
WHAT ARE YOU SEEKING TREATMENT FOR?			
WHEN DID YOUR SYMPTOMS BEGIN?		**NEXT DOCTOR'S APPOINTMENT:**	
MY SYMPTOMS ARE:	☐ Getting Better ☐ The Same ☐ Getting Worse	☐ Consistent ☐ Changing	☐ Constant ☐ Sporadic
WHAT MAKES YOUR SYMPTOMS BETTER?			
WHAT MAKES YOUR SYMPTOMS WORSE?			

HAVE YOU RECEIVED ANY OF THE FOLLOWING TREATMENTS FOR THE SAME CONCERN IN THE PAST?

☐ **Physical Therapy** ☐ **Chiropractic** ☐ **Massage**

☐ **MRI:** Date ____ / ____ / _____ ☐ **X-Ray:** Date ____ / ____ / _____ ☐ **CT Scan**: Date ____ / ____ / _____

☐ **Other (specify):**

*Providing email authorized online correspondence including newsletters, event notifications, etc.

PLEASE LIST MEDICAL HISTORY (PRIOR SURGERY, FALL, PACEMAKER, ETC.) INCLUDING DATES:

HAVE YOU NOTICED ANY OF THE FOLLOWING (CHECK ALL THAT APPLY):		
☐ Shortness of breath	☐ Changes in bladder or bowel	☐ Fever/chills/sweats
☐ Dizziness or lightheadedness	☐ Changes in appetite	☐ Increased swelling
☐ Weakness or fatigue	☐ Nausea or vomiting	☐ Numbness or tingling
☐ Difficulty maintaining balance	☐ Difficulty swallowing	☐ Pain at night
☐ Headaches	☐ Weight loss/gain	
☐ Other (describe):		

ARE YOU PREGNANT?	☐ Yes	☐No
DO YOU SEE YOUR PHYSICIAN ANNUALLY?	☐ Yes	☐No
DURING THE PAST MONTH, HAVE YOU BEEN BOTHERED BY…		
Feeling down, depressed or hopeless?	☐ Yes	☐No
Little interest or pleasure in doing things?	☐ Yes	☐No
IS THIS SOMETHING WITH WHICH YOU WOULD LIKE HELP?	☐ Yes	☐No

LIST ALL MEDICATIONS, VITAMINS, SUPPLEMENTS, AND OVER-THE-COUNTER DRUGS (OR ATTACH A DETAILED LIST). ENTER NAME : DOSE : FREQUENCY : FORM (PILL, OINTMENT, PATCH, INHALER, INJECTION):
•
•
•
•
•
LIST ANY MEDICATION(S) YOU ARE ALLERGIC TO AND YOUR REACTION:
•
•
•
LIST ANY OTHER ALLERGIES (I.E. LATEX, ADHESIVES):
•
•

DO YOU USE TOBACCO?	**If yes, ENTER TYPE : AMOUNT : FREQUENCY**
DO YOU DRINK ALCOHOL?	**If yes, ENTER AMOUNT : FREQUENCY**
PLEASE PROVIDE ANY OTHER INFORMATION THAT IS PERTINENT TO YOUR HEALTH & WELLNESS:	

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Name of Patient or Legally Authorized Representative: _____

Signature: _____ Date: _____ /_____ / _____

SMITH PHYSICAL THERAPY AND RUNNING ACADEMY, LLC
AUTHORIZATION FOR RECIEPT & RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____

I, _____ , hereby authorize Smith Physical Therapy and Running Academy, LLC to receive and/or disclose my protected health information, as described below, from or to, any healthcare professionals who have or will treat me, insurance providers, and government agency. Receipt and disclosure of my protected health information may be for the purpose of treatment, coordination of treatment with any of my other healthcare providers, payment purposes, and any disclosures required by law. Such information will allow Smith Physical Therapy and Running Academy, LLC to coordinate with other healthcare professionals to create a healthcare plan based on all relevant medical information. Any such use or release of information will be limited to that which is necessary for the purpose in which the information is required.

Information Authorized to be Disclosed:

- ☒ Medical records, including but not limited to ER records, admission and discharge summaries, patient history, dictated reports and consults, operative and procedure reports, intraoperative and procedure flow sheets, informed consents, physician orders, progress notes, nurses notes, flow sheets, medication and transfusion records, test results, laboratory reports, photographs, pathology reports, EKGs, office records, immunization records, radiology and other diagnostic reports and patient instructions.
- ☒ Radiology and other diagnostic imaging films, including but not limited to photos, x-rays, CT scans, MRIs, ultrasounds and angiograms.
- ☒ Invoices and bills relating to medical services rendered to the undersigned.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that the records have already been used or released. Unless revoked earlier, this authorization will expire 12 months from the date of signing. This authorization may be revoked by making a written request to Smith Physical Therapy and Running Academy, LLC, located at 215 Exchange Drive, Crystal Lake, Illinois 60014.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that Smith Physical Therapy and Running Academy, LLC cannot condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing of the authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA laws or state laws.

I acknowledge that I have received a copy of this authorization.

PARTICIPANT SIGNATURE: _____ **DATE**: ____ /____ / ____

If participant is a minor:

NAME OF PARENT OR GUARDIAN: _____

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE**: ____ /____ / ____

SMITH PHYSICAL THERAPY AND RUNNING ACADEMY, LLC
CONSENT TO TREATMENT AND WAIVER OF LIABILITY

PATIENT NAME: _____

I, _____, hereby consent to and authorize Smith Physical Therapy and Running Academy, LLC to provide treatment through any physical therapist or healthcare professional that Smith Physical Therapy and Running Academy, LLC employees. My consent to treatment shall include, but not be limited to, any treatment prescribed by or suggested by my physical therapist, physician, and/or health care provider.

I agree to release Smith Physical Therapy and Running Academy, LLC from all liability relating to injuries that may occur during any physical therapy session, while on or off the premises of Smith Physical Therapy and Running Academy, LLC is located, during any activities held by Smith Physical Therapy and Running Academy, LLC. By signing this agreement, I agree to hold Smith Physical Therapy and Running Academy, LLC entirely free from any liability, including financial responsibility for injuries incurred, costs, and damages. I assume all risk of harm or injury which might occur while I participate in any activities.

I acknowledge the risks involved in receiving physical therapy, which includes but is not limited to: manual therapy, women's health sessions, healthy tissue maintenance sessions, injury screenings, technique drills, strengthening drills, flexibility drills, proprioception exercises, balance drills, any other drills or exercises I participate in through Smith Physical Therapy and Running Academy, LLC, activities related to home exercise programs prescribed by any physical therapist employed by Smith Physical Therapy and Running Academy, LLC, and movement assessments. I state that I am participating voluntarily, and that all risks have been made clear to me. Additionally, I do not have any undisclosed conditions that will increase my likelihood of experiencing injuries while engaging in any activities.

By signing below I forfeit all right to bring a suit against Smith Physical Therapy and Running Academy, LLC for any reason. I will also make every effort to obey safety precautions as listed in writing and explained to me verbally. I will ask for clarification when needed and inform my physical therapist or any staff members when I am feeling any pain or discomfort or feel I can no longer participate in the activity. Further, if any injury does occur, I give my consent to Smith Physical Therapy and Running Academy, LLC to contact the party provided below as my emergency contact person.

If the participant is a minor, I agree that the minor has my consent to participate in any physical therapy treatments or activities listed above. I further provide my consent for the organization or business named above to seek emergency treatment for the minor if necessary. I agree to accept financial responsibility for the costs related to the emergency treatment.

EMERGENCY CONTACT: _____ **PHONE**: (_____) _____-_____

PARTICIPANT/GUARDIAN SIGNATURE: _____ **DATE**: ____ /____ / ____

SKY HIGH ATHLETIC CENTER AND SKY HIGH VOLLEYBALL, INC.
WAIVER AND RELEASE LIABILITY FORM

NOTE: This form must be read and signed before the participant is allowed to take part in any training, league, competition, meeting, or testing sessions. *By signing this form, the participant affirms having read it*.

PARTICIPANT'S NAME: (Please Print) _____

Sponsoring Organizations: Sky High Athletic Center and Sky High Volleyball, Inc.

In consideration of my involvement under the auspices of the sponsoring organizations, I acknowledge and agree that:

1. I risk bodily injury, including paralysis, dismemberment, and death, as well as loss of or damage to property;

2. I knowingly and freely assume all such risk; and

3. I, for myself, and on behalf of my heirs, assigns, and next of kin, hereby release, hold harmless and promise not to sue Sky High Athletic Center, Sky High Volleyball, Inc., their officers, official agents and/or employees, schools or organizations furnishing gyms, classrooms or other related facilities, with respect to any and all such injury, paralysis, dismemberment, death and/or loss or damage to property except that which is the result of gross negligence and/or willful or wanton misconduct.

I have read the above waiver and release, understand that i have given up substantial rights by signing it and sign it voluntarily.

_____ _____
(Participant's Signature) (Date Signed)

FOR ATHLETES OF MINORITY AGE
(Under age 19 at the time of registration)

This is to certify that I, as a parent/guardian of the participant, do consent to his/her release of Sky High Athletic Center and Sky High Volleyball, Inc. from any and all liabilities incident to his/her involvement in the programs conducted by of Sky High Athletic Center and Sky High Volleyball, Inc. We have read the above waiver and release, understand that we have given up substantial rights by signing it and sign it voluntarily.

_____ _____
(Parent/Guardian Signature) (Date Signed)

_____ _____
(Parent/Guardian Printed Name) (Relationship)

In Cooperation With

SMITH PHYSICAL THERAPY AND RUNNING ACADEMY, LLC
PHOTOGRAPHY AND DIGITAL MEDIA RELEASE

PATIENT NAME: _____

I, _____ , agree that while I am participating in activities or sessions conducted by Smith Physical Therapy and Running Academy, LLC, I may be photographed or videotaped from time-to-time during said participation, and give my consent to be photographed or videotaped.

I hereby grant to Smith Physical Therapy and Running Academy, LLC perpetually, exclusively, and for all media (including print, CD-ROM, DVD, internet, and any other electronic medium presently in existence or invented in the future), the right to incorporate (alone or together with other materials), in whole or in part, photographs or video footage taken of me as a result of participating in activities provided by Smith Physical Therapy and Running Academy, LLC. I also consent to the use of my name, image, likeness, voice and/or picture, and other material about me for promotional, publicity, or organizational purposes. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in marketing materials or other business publications. I understand and agree that publication of said photographs confers no rights of ownership or royalties whatsoever. I also agree that I waive any right to inspect or approve of the use of any of the materials.

I agree that I will not bring or consent to others bringing a claim or action against Smith Physical Therapy and Running Academy, LLC on the grounds that anything contained in the property, or in the advertising and publicity used in connection herewith, is defamatory, reflects adversely on me, violates any other rights whatsoever, including, without limitation, rights of privacy and publicity. I hereby release Smith Physical Therapy and Running Academy, LLC, its members, managers, or successors from and against any and all claims, demands, causes, suits, costs, expenses, liabilities, and damages whatsoever that I may hereafter have against Smith Physical Therapy and Running Academy, LLC.

I understand that I have the right to revoke my consent. Revocation of consent must be in writing and provided to Smith Physical Therapy and Running Academy, LLC. I also understand that revocation of consent will only apply going forward from the date of revocation. Smith Physical Therapy and Running Academy, LLC shall retain the right to continue to produce or use any advertising, marketing, promotional, or organizational materials that use my name, image, likeness, voice and/or picture and were created or designed before I revoked my consent. For example, if Smith Physical Therapy and Running Academy, LLC publishes a brochure incorporating my picture before I revoke my consent, Smith Physical Therapy and Running Academy, LLC can still produce and use the brochure with my picture after revocation. However, if it were to later create a promotional video that did not exist until after I revoked my consent, Smith Physical Therapy and Running Academy, LLC would not have the right to use my name, image, likeness, voice and/or picture in said video.

This agreement shall not obligate Smith Physical Therapy and Running Academy, LLC to use the property or to use any of the rights granted hereunder, or to prepare, produce, exhibit, distribute or exploit the property.

PARTICIPANT SIGNATURE: _____ **DATE**: ____ /____ / ____

If participant is a minor:

NAME OF PARENT OR GUARDIAN: _____

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE**: ____ /____ / ____