



Mailing Address: P O Box 1358, Summit, MS 39666

709 Robb St, Summit, MS 39666

101 W Freedom Rd, Liberty, MS 39645

4916 Plaza Dr, Tylertown, MS 39667

OFFICE: 601-276-2200 FAX: 601-276-3300

Patient Information

Name _____ Date of Birth _____
SSN _____ Martial Status _____ M _____ S _____ D _____ W _____
Address _____ Gender _____ M _____ F _____
City _____ State _____ Zip _____
Home _____ Cell _____ Work _____

I expressly consent to receive SMS text messages from Fortinberry Physical Therapy regarding appointment follow-ups, satisfaction surveys, and feedback requests. I understand that messages will be sent using an automated system by Rate Follow Up on behalf of Fortinberry Physical Therapy. To view the Rate Follow Up Privacy Policy, visit ratefollowup.com and select "Privacy Policy" from the page menu, or go directly to ratefollowup.com/privacy-policy. YES NO

Responsible Party Name _____
Date of Birth _____ SSN _____
Address _____ City _____ State _____ Zip _____
Employer/School _____ Occupation/Sport _____
How did you hear about Fortinberry Physical Therapy? _____

Primary MD _____
Referring MD _____
Reason for visit today? _____
Date Symptoms began? _____ Date of Surgery/Injury _____
If known, when is your next Dr follow-up scheduled? _____

Emergency Contact _____ Phone _____

Privacy Policy: I have read the Health Information Privacy Policy

Signature _____ Date _____

Billing: Co-pays and deductibles will be collected at the time of service. Fortinberry Physical Therapy will bill your insurance. Please keep in mind that the co-pays collected at the time of your service are an estimate of your cost based on benefits quoted by your insurance company and you may be responsible for unpaid or disallowed amounts.

Printed Name _____ Signature _____
Date _____



Arthritis

YES___NO___

Osteoporosis

YES___NO___

Asthma

YES___NO___

COPD/ARDS (Emphysema)

YES___NO___

Angina

YES___NO___

Congestive Heart Failure

YES___NO___

Heart Disease

YES___NO___

Heart Attack

YES___NO___

High Blood Pressure

YES___NO___

Neurological Disease (Parkinson's or Sclerosis)

YES___NO___

Stroke or TIA

YES___NO___

Pacemaker

YES___NO___

Seizures

YES___NO___

Peripheral Vascular Disease

YES___NO___

Headaches

YES___NO___

Diabetes Type I or II

YES___NO___

Gastrointestinal Disease (Ulcer, Hernia

Reflux, Gallbladder)

YES___NO___

Visual Impairment (Glaucoma, Cataracts)

YES___NO___

Hard of Hearing

YES___NO___

Back Pain, Neck Pain, Degenerative
Disease, Spinal Stenosis

YES___NO___

Kidney, Bladder, Prostate, or Urination
Problems

YES___NO___

Previous Accidents

YES___NO___

Allergies

YES___NO___

Incontinence

YES___NO___

Anxiety or panic disorders

YES___NO___

Depression

YES___NO___

Other Disorders

YES___NO___

Hepatitis, Tuberculosis, or other
Blood-Borne Condition

YES___NO___

Prior Surgery

YES___NO___

Prosthesis/Implants

YES___NO___

Sleep Dysfunction

YES___NO___

Cancer

YES___NO___

Height_____Weight

Dominant Hand Left_____Right

ARE YOU CURRENTLY BEING TREATED BY HOME HEALTH (EXAMPLES: WOUND CARE/IV CARE /NURSE VISITS /THERAPY) OR BY ANOTHER PHYSICAL THERAPIST? YES_____NO_____

Explanation of any questions answered yes: _____

Other medical conditions or prior surgeries: _____

Current medications: _____



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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Fortinberry Physical Therapy does not guarantee what your reaction will be to specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Printed Name_____ **Signature**_____

Date_____