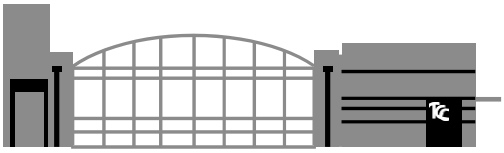

THE NATE WATERS
PHYSICAL THERAPY CLINIC
AT TULSA COMMUNITY COLLEGE

Application Form

Name:_____**First** _____**Last**

Male/Female Married/Single/Other DOB:_____

Home Address:_____City_____State_____Zip_____

Phone(Personal)_____Phone(work)_____e-mail_____

How would you like for us to contact you? □Phone Call □Text Message □e-mail

If you would like to be contacted by text message please list your cell phone number:_____

Emergency Contact_____Relationship_____

Phone_____ Other Means of Contact_____

What are your concerns or reasons for visiting our clinic? What are your treatment goals?

_____

_____

Do you have a physician referral in hand? □yes □no

Do you have a primary care physician? _____

Physician's Practice Name or Group:_____

Physician Phone Number_____Address_____

How did you find out about the Nate Waters Physical Therapy Clinic? Who referred you to the clinic?_____

_____

Health History

How would you rate your health over all? □Excellent □Very Good □Good □Fair □Poor

Have you been hospitalized in the past 6 months to year? □No □Yes, if yes please explain:

_____

_____

Have you had Physical Therapy in the past year? □No □Yes, If yes please why and where did you receive services?

_____

_____

Are you currently employed or going to school? □No □Yes, If so where and in what capacity?

_____

_____

Are you allergic to anything? □No □Yes, If yes please list: (You may use the back if needed)

_____

_____

Have you had any surgeries? □No □Yes, If yes please list and give a date of when the surgery occurred:

_____

_____

_____

Do you take any prescribed medications? □No □Yes, If yes please list:

_____

_____

Do you have take any over the counter medications, vitamins or supplements? □No □Yes, if so what:

_____

_____

Past Medical History (Check all that apply)

□MRSA	□Diabetes	□Hypertension	□Mitral Valve Prolapse
□Heart Attack	□Congestive Heart Failure	□Blood clots	□Irregular Heart Beat
□Pacemaker	□Internal Pacemaker	□Asthma	□COPD
□Anxiety	□Emphysema	□Tuberculosis	□Heartburn/Gastric Reflux
□Hiatal Hernia	□Cirrhosis	□Hepatitis	□Gallbladder Disease
□Stomach Ulcer	□Thyroid Disease	□Kidney Stones	□Kidney Infection
□Kidney dialysis	□Anemia	□Bruising	□HIV/AIDS
□Stroke/TIA	□Seizures	□Alzheimer's	□Parkinson's Disease
□Headaches	□Fibromyalgia	□Spinal Cord Injury	□Artificial Joint □Arthritis
□Depression	□Mental Illness	□Metal implants	□Infusion Pump (indwelling)
□Osteoporosis	□Osteopenia	□Vitamin Deficiency	

□Cancer, if so what type?_____

□Other_____

CONSENT TO TREATMENT: I consent to services at the Nate Waters Physical Therapy Clinic at Tulsa Community College. In so doing I understand that services will have an educational objective and that students will be involved in the service delivery. I also understand that services may involve bodily contact, touching and/or direct contact which may seem to be of sensitive nature but that my comfort and modesty will be addressed at all times. I understand that I have the right to refuse and withdraw from service provision at any time.

Initials _____

TREATMENT OF MINORS: I, as a parent or legal guardian give consent to services as directed by the Physical Therapist upon being informed of such services as listed in the recorded plan of care. I understand that I shall be on premises at all times and will cooperate fully with the students, staff, faculty and practitioners of the Nate Waters Physical Therapy Clinic.

Initials _____

LIABILITY: I know and agree that the Nate Waters Physical Therapy Clinic at Tulsa Community College is not responsible for lost/damaged personal items.

Initials _____

WAIVER AND RELEASE: I hereby release, discharge and acquit the Nate Waters Physical Therapy Clinic at Tulsa Community College, it's agents, representatives, affiliates, employees or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Initials _____

NOTICE OF PRIVACY PRACTICES: I hereby assign all benefits directly to the Nate Waters Physical Therapy Clinic at Tulsa Community College and authorize release of any medical records necessary to facilitate my treatment process. I have been given information regarding HIPAA, in regard to confidentiality and use of my personal health information.

Initials _____

MEDICAL RECORDS: I understand that Nate Waters Physical Therapy Clinic and personnel will not fill out medical paperwork to include forms for social security disability and workers comp. I also understand that I have the right to obtain my medical records.

Initials _____

I certify that all information provided here is true and correct.

_____ _____

Patient/Guardian Witness

HIPAA Release Form

Patient Name: _____ Date of Birth: _____

Release of Information

□ I authorize the release of information including the diagnosis, records, examination, and treatments rendered to me.

This information may be released to:

□ Spouse _____

□ Child(ren) _____

□ Other _____

□ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

_____ _____

Patient/Guardian Date

Email and Cell Phone Use Policy

I consent and state my preference to have Nate Waters Physical Therapy Clinic (NWPTC) communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, home exercise programs and appointments. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

I understand that Nate Waters Physical Therapy Clinic does not bill insurance or accept payment of any sort. NWPTC also does not communicate PHI to other entities such as doctor's offices via electronic methods. Based on this information and the rules of HIPAA, NWPTC does not have to comply with HIPAA rules, but NWPTC will make every attempt to comply.

_____ I consent to receive emails. _____ I DO NOT consent to receive emails.

_____ I consent to receive text messages. _____ I DO NOT consent to receive text messages.

_____ _____

Signature Date