# PHYSICAL THERAPY WELCOME PACKET

Thank you for choosing Michael Johnson Physical Therapy. This welcome packet contains six forms. Please see instructions below and complete the forms accordingly.

1. New patient Information Form – Please complete as thoroughly as possible.
2. Medical History Form – Please fill out this medical history form so that your physical therapist can get better acquainted with your medical history. We realize that not all of the questions pertain to you, but please answer all questions that apply.
3. Waiver and Release – Sign and date (front office will fill in item #1).
4. Credit Card Authorization Form – Please complete as thoroughly as possible.
5. Privacy Policy – For you to read and keep.
6. Patient Bill of Rights – For you to read and keep.
7. Policies and Procedure – Please sign and return.

Please fax the forms to MJP at 469-424-6575, scan and email them to kelcey@michaeljohnsonperformance.com, or bring them by the MJP facility at 6051 Alma Drive, McKinney, TX 75070.

If you have any questions, please call the front desk at 469-424-6572. Thanks again and we look forward to helping you or your athlete reach their full potential.

– *Your Michael Johnson Physical Therapy Team*

# NEW PATIENT INFORMATION

Patient Name: _____

Address: _____ City, State, Zip _____

DOB: _____ SS #: _____ Email: _____

Phone Numbers: (H) _____ (W) _____ (C) _____

Emergency Contact: _____ Phone: _____

How did you hear about us? Doctor: _____ Friend: _____ Website_____ Flyer_____ Coach: _____ Other: _____

Name of Insured: _____ Insureds DOB: _____

Insureds Employer: _____ Member ID #_____ Group #: _____

Diagnosis: _____ Referring Physician: _____

X-Ray: Yes/ No MRI: Yes/No Date last seen by Physician: _____

Insurance Carrier: _____

Billing Address: _____ City, State, and Zip: _____

Phone Number: _____ Fax Number: _____

Case Manager's Name: _____ Phone/Fax: _____

I have been given my insurance benefits and fully understand my responsibility. I understand that I am encouraged to contact my insurance company to verify that the benefits quoted by Michael Johnson Physical Therapy are correct. Michael Johnson Physical Therapy is not responsible for misquoted insurance benefits.

Signature of Patient and/or Legal Guardian: _____ Date: _____

# MEDICAL HISTORY FORM

Patient Name: _____ Age:_____

Reason for therapy: _____

Current medications: _____

Allergies: _____

Health History: (If yes, please check box and explain, providing approximate dates)

- ☐ Heart condition/ Heart attack _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Asthma _____
- ☐ High Blood Pressure _____
- ☐ Cancer _____
- ☐ Anemia _____
- ☐ Seizures/ Epilepsy _____
- ☐ Severe/ Chronic Headaches _____
- ☐ Arthritis _____
- ☐ Pacemaker _____
- ☐ Osteoporosis _____
- ☐ Kidney Disease _____
- ☐ Hepatitis/ Jaundice _____
- ☐ Loss of hearing _____
- ☐ Circulatory Problems _____
- ☐ Recent weight loss/ gain _____
- ☐ Dizziness/ Loss of balance _____
- ☐ Incontinence _____
- ☐ Other _____

Is there any chance you may be pregnant at this time? Yes/ No
If yes, due date:_____

During the last 5 years have you:
Been admitted to a hospital or had surgery? Yes/ No
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Had any previous orthopedic problems or injuries? Yes / No
If yes, please explain: _____

Received any physical therapy treatments: Yes / No
If yes, for what condition(s)? _____

Are you currently receiving treatments from another medical provider? (i.e., home health, chiropractic, etc.) Yes / No
If yes, please explain: _____

Have you had any special medical test or studies: (i.e., X-Ray, MRI, etc.) Yes / No
If yes, please explain: _____

Signature of Patient and/or Legal Guardian:_____ Date: _____

Signature of Physical Therapist:_____ Date: _____
(Title)

# CONTINUING WAIVER AND RELEASE OF LIABILITY AND IDEMNIFICATION

I, _____, am executing the following Continuing Waiver and Release of Liability and Indemnification (this "Release") as a condition to

Enrollment as a participant ("Participant") in the athletic training services (the "MJP Training Sessions") offered by Michael Johnson Performance, Inc. ("MJP"). As used herein, the term "MJP Training Sessions" shall mean and include athletic training services and related counseling, training and testing activities, Which may include, but are not limited to, nutritional counseling, sports psychology counseling, sports vision testing and training, biomechanical assessment, physical therapy and hydrotherapy. This Release covers all MJP Training Sessions wherever and whenever they may be held, whether at Michael Johnson Performance in Craig Ranch, 6051 Alma Drive, McKinney, Texas 75070, or some other location. By signing below, I, as the Participant (or, if applicable, Participant's legal guardian) expressly understand, assume and consent to all the terms, conditions and risks set forth herein.

1. Continuing Nature of Release. This Release covers all future MJP Training Sessions that I participate in until it is expressly terminated by me in writing, such that MJP may rely upon this Release in permitting my enrollment in any number of MJP Training Sessions over any period of time subsequent to the effective date shown below. I acknowledge that, if I am under the care of a physician, it is my obligation to consult with my physician before commencing any new MJP Training Sessions, and I agree to do so and to advise MJP if I have been advised against participation in the MJP Training Sessions by my physician.
2. Participants t's Assumption of Risk.
   A) I represent that I am at least eighteen (18) years of age or older, or, if I am not 18 years of age, that this Release has been countersigned on my behalf by my legal guardian. I hereby further state that I currently suffer from no physical or mental condition that would impair my ability to fully participate in the MJP Training Sessions.
   B) By signing below, I further understand and agree that participation in the MJP Training Sessions is voluntary, and that such participation carries with it certain inherent and unavoidable risks, including an increased risk of serious illness, injury, paralysis, or even death. With full awareness of such risks, I agree that I assume the risk of participating in the MJP Training Sessions, including any such risk of death, injury and other losses and damages sustained by me arising out of or in connection with the MJP Training Sessions or any system or equipment used in connection with the MJP Training Sessions. I further understand and agree that the MJP Training Sessions involve a variety of activities requiring intense physical activity at a high intensity heart rate level and I acknowledge that MJP has advised me I should consult with my physician before participating in the MJP Training Sessions. I certify that I am physically fit and sufficiently trained for participation in the MJP Training Sessions and that I have not been advised against participation by a qualified health professional.
   C) If I am under the care of a physician, my enrollment in the MJP Training Sessions will be made known to my physician by me. My involvement in the MJP Training Sessions will be in accordance with my physician's instructions regarding the MJP Training Sessions. MJP and its respective representatives shall in no way be responsible for my compliance with my physician's instructions. I expressly agree that I am solely responsible for my compliance with my physician's instructions.
   D) I shall be liable for any damages to MJP or its property caused by me or my guests.
3. Indemnification. I hereby indemnify, release and discharge MJP and its owners, directors, officers, employees and agents from any liability, claims, losses, judgments, costs, or expenses arising directly or indirectly from my participation in the MJP Training Sessions, including claims or damages resulting from death, personal injury, partial or permanent disability or property damage, medical or economic losses, including attorney's fees, whether caused in whole or in part from any instruction or training hereunder and whether based upon the breach of any express or implied warranty, negligence or under any other legal theories. I further indemnify, release, and forever discharge MJP from any liability, claims, losses, costs or expenses arising directly or indirectly from my use of the Michael Johnson Performance center or MJP Training Sessions.
4. Disclaimer
   A) I hereby acknowledge that the MJP Training Sessions are provided "AS IS", without warranties of any kind, express or implied, nor am I guaranteed any individual results. I am personally responsible for the achievement of my individual performance goals. I further understand and agree that MJP and its respective representatives expressly disclaim any and all express or implied warranties arising by law, conduct, or otherwise and any other alleged obligation or liability arising from contract negligence, tort, or otherwise, including, but not limited to, the implied warranties of merchantability and fitness for a particular purpose with respect to the MJP Training Sessions or any products or services offered or endorsed by MJP or its respective representatives. Under no circumstances shall MJP or its respective representatives be liable for special, indirect, incidental or consequential damages of any nature whatsoever.
   B) I hereby waive and release MJP and its respective representatives from any claims based on any oral or written statements made prior to or contemporaneous with this Release and disclaim any reliance on any such statements.
5. Acknowledgement of Release Terms and Conditions. I acknowledge that this Release shall be binding upon me and my respective heirs, executors, administrators and legal representatives. As used herein, the terms "Participant," "I," and "me" or "my" shall also refer to and include my legal guardian or other authorized representative that signs this Release on behalf of me. In the event that Participant is a minor, any person signing this Release on behalf of Participant hereby represents and warrants to MJP that he or she is in fact duly qualified at law to act for and bind Participant, and is authorized to do so. As used herein, the term "MJP" shall include its duly authorized directors, officers, employees and agents. This Release commences in effect as of the date shown below and shall continue in effect not only for the MJP Training Sessions referenced above, but for any and all future activities that I may engage in under the supervision of MJP, regardless of whether such activities are conducted at the Michael Johnson Performance Center or elsewhere, such that it shall not be necessary for me to execute a separate Release each time I engage the services of MJP, although I agree to do so if requested by MJP in the future.
6. I understand that MJP may collect information from or about me including but not limited to, my name, image, birth date, contact information, physical characteristics and other information about my body, athletic performance, and physical condition. I acknowledge that MJP will store this data in the United States and may use the data for any lawful purpose, including but not limited to, designing and improving products, providing performance evaluations to me and my coaches, and better understanding the impacts of specific activities and products on athletic performance over time. MJP may also share the data it collects with affiliated companies and partners, including Nike, Inc."

IN WITNESS WHEREOF, this Release is executed to be effective as of _____ (Date)

| PARTICIPANT | PARTICIPANT'S LEGAL GUARDIAN | MICHAEL JOHNSON PERFORMANCE, INC. |
|---|---|---|
| _____ | _____ | _____ |
| (Print Name) | (Print Name) | (Print Name) |
| _____ | _____ | _____ |
| (Signature) | (Signature) | (Signature) |

# CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize Michael Johnson Physical Therapy to charge my credit card account in the amount charged per session based on method of payment.

**Payment Method's**: (Please check preferred method of payment)

- ☐ MEDICAL SAVINGS ACCOUNT (MSA)
- ☐ INSURANCE
- ☐ FLAT RATE ($75 per visit)

**Flat rate transaction option:**

- ☐ DAILY
- ☐ WEEKY
- ☐ BI-MONTHLY

**Payment information:**

☐ Visa ☐ MasterCard ☐ Discover

MSA/Credit Card Number: _____

Expiration Date: _____ /_____ VID Code: _____

**Credit card billing address:**

Cardholder Name: _____

Street: _____

City: _____State: _____ Zip Code: _____ – _____

Country: (If not US) _____

Telephone: _____

Cardholder Signature: _____ Date: _____

We ask to keep your credit card number or Health Savings Account number on file to guarantee appointment attendance, co-pays and deductibles. Your credit card will be automatically charged for the balance of any outstanding accounts (including service charges, co-pays and deductibles) that are delinquent beyond 60 days.

Your completion of this authorization form helps us to protect you, our valued customers, from credit card fraud. Michael Johnson Performance will keep all information entered on this form strictly confidential

# PRIVACY POLICY

Michael Johnson Physical Therapy strongly believes in protecting the confidentiality and security of information we collect about you. This notice describes our privacy policy and describes how we treat the information we receive about you.

- Why we collect and how we use information: We collect and use information for business purposes with respect to our health care provider relationship with you. These business purposes include administering our products and services and processing transactions related to this service.

- How we collect information: We get most information directly from you. The information that you give us when registering for our products or services provides the information we need. If we need to verify information or need additional information we may obtain information from third parties such as insurers, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations or other personal characteristics, as well as transactions with us or others.

- How we protect information: We treat information in a confidential manner. Our employees are required to protect the confidentially of information. Employees may access information only when there is an appropriate reason to do so, such as administer or offer our products or services. We may also maintain physical, electronic and procedural safeguards to protect information; these safeguards comply with all applicable laws established by the *Health Insurance Portability and Accountability Act.* Employees are required to comply with our established policies.

- Information Disclosure: We may disclose any information we believe it is necessary for the conduct of our business, or where law requires disclosure. For example, information may be disclosed to others to enable them to provide business services for us, such as helping us to evaluate requests for insurance benefits, to perform general administrative activities or to otherwise assist us in servicing or processing a health care product or service. Information may also be disclosed for audit or research purposes, or to law enforcement and regulatory agencies, for example, to help us prevent fraud. Information may be disclosed to others such as companies that process data for us, companies that provide general administrative services for us, and other healthcare providers. We may make other disclosures of information as permitted by law.

- We may also provide information: (i) to others to assist us in offering our products and services to you, and (ii) to companies with which we have a joint marketing agreement. We do not make any other disclosures of information to other companies who may want to sell their products or services to you. For example, we will not see your name to a catalog company.

- Access to and correction of information: Generally, upon your written request, we will make available information for your review that we are not prohibited from disclosing. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future discloser information.

For additional information regarding our privacy policy, please contact us at Michael Johnson Performance, 6051 Alma Drive, McKinney, TX 75070; 469-424-6572.

This privacy notice is HIPPA (Health insurance portability and accountability act) Compliant

By signing below, I have read, and acknowledged the HIPPA policy set forth by Michael Johnson Physical Therapy.

Signature: _____ Date: _____

If you would prefer to NOT receive your copy of this for please initial here: _____

# PATIENT BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his health care provider complete and current information concerning his diagnosis, treatment, and prognosis in terms the patient can reasonably expect to understand. When it is not medically possible to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the health care provider responsible for coordinating his care.

3. The patient has the right to receive from his health care provider information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5. The patient has the right to create advanced directives, such as a living will.

6. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

7. The patient has the right to expect that all communication and records pertaining to his care should be treated as confidential.

8. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians and other health care providers are available and where. The patient has the right to expect that the hospital or health care provider will provide a mechanism whereby he is informed of his continuing health care requirement following discharge.

9. The patient has the right to examine and receive and explanation of his bill regardless of source of payment.

10. The patient has the right to know what rules and regulations apply to his conduct as a patient.

# POLICIES & PROCEDURES

- Cancellation Policy: I understand that a $25 fee will be assessed for each appointment that I schedule but do not attend, or that is rescheduled with less than 24 hour advance notice. Michael Johnson Physical Therapy reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstance. This fee is not reimbursable by your insurance carrier.

- Authorization for medical information release: I authorize Michael Johnson Performance to furnish my insurance company with medical information they may request regarding my condition or treatment. Furthermore, I authorize my referring healthcare provider to release any diagnostic reports and/or surgery reports to Michael Johnson Physical Therapy.

- Privacy notice of Patient Bill of Rights: I have read and understand Michael Johnson Physical Therapy Privacy Notice and Patient Bill of Rights. I certify that I am 18 years of age and/or the legal guardian/ guarantor of the patient named below.

Printed Name of Patient: _____Date: _____

Signature of Patient and/or Legal Guardian: _____