CAMERON PARK PHYSICAL THERAPY CENTER

"The Thought Behind Quality Physical Rehabilitation"

Informed Consent for Physical Therapy Services

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. C.P.P.T. does not guarantee what your reaction will be to a 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 the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with you treating physical therapist throughout your treatment.

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.

****_____ _____ _____**

****Patient Print Name Patient/ Guardian Signature Date**

Text message and/or Email Reminder's Consent Form

I, _____, give Cameron Park Physical Therapy Center, Inc. permission to send an automatic TEXT or EMAIL appointment reminder.

TEXT:

I release the following information to receive automatic text message reminders from Cameron Park Physical Therapy. I understand that such messages may contain health information.

Cell phone Carrier: _____

Cell phone number: _____

**Regular text messaging rates apply to patient. **

****_____ _____**

****Patient or Guardian signature: Date:**

EMAIL:

I release the following information to receive automatic email reminders from Cameron Park Physical Therapy. I understand that such messages may contain health information.

Email address: _____

****_____ _____**

****Patient or Guardian signature: Date:**

Patient Denies **text/email** reminder consent: _____

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Patient Information

Please complete all of the following information thoroughly:

Name:_____
Last First Middle Occupation

Mailing Address:_____
Street/P.O. Box City State Zip

Residence(if different):_____
Street City State Zip

(_____)_____(_____)_____(_____)_____
Home Phone Work Phone Cell Phone

_____
Date of Birth Age Sex Social Security # Drivers License # Email Address

_____
Nearest Relative/Emergency Contact Phone # How did you hear about us?

Work Information:_____
Name Address Phone

Referring Physician:_____
Name Phone

If Party is a minor:_____
Name of Insured Parent Social of Insured Parent Date of Birth

Diagnosis:_____ Date of Injury:_____

Circle Yes or No:

1. Is this condition related to an injury on the job? Yes No
   If yes please provide workers compensation information below

2. Is this injury related to a Motor Vehicle Accident? Yes No
   If yes, what state was the accident located: _____
   If yes, please provide your auto insurance information below

3. Is this injury involved or will be involved in litigation? Yes No
   If yes, please provide attorney information below

Yes answers:_____

_____

I authorize Cameron Park Physical Therapy to release and request information to/from insurance companies and all medical providers.
I authorize assignment of benefits directly to this clinic

_____

Patient or Guardian Signature **Date**

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Office Policies

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All patients must recognize that they are responsible for the charges incurred for physical therapy. We will attempt to verify what your insurance benefits are. However, quotation of benefits from your insurance company does not guarantee payment. We will submit billing to your insurance company free of charge. In the event that your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment
Missed appointments are a loss for everyone. Cancellations without adequate notice cannot be filled and take valuable time from other patients, thus they are subject to a ***$25 late cancel/no show fee***. Therefore, we require that you notify us 24 hours in advance if you are unable to attend a scheduled appointment. If you are 15 minutes late or greater, the therapist will have the option of seeing you or rescheduling. Checks that are returned for any reason are subject to a $10 service fee. . **No Cell Phone's until after your appointment please.**

Authorization and Assignment of Benefits:
I hereby authorize and direct you, my insurance company, to pay directly to Cameron Park Physical Therapy Center, Inc. such sums as may be due and owing this office for services rendered to me, both by reason of accident of illness, and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment , or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.
In the event my insurance company, obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the amounts due this office for their services. I further understand and agree that this assignment and authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.
I authorize this office to release any information pertinent to my case to any insurance company, billing service, adjuster, or attorney to facilitate collection under this assignment and authorization.

MEDICARE PATIENTS: We bill our standard fees to Medicare, they pay 80% of their allowable fees, and the difference is billed to your secondary insurance. If you do not have a secondary insurance or your secondary insurance denies payment, you will receive a statement following the receipt of Medicare's allotment. Unless other arrangements are made, you will be responsible for the remaining 20% of the Medicare allowable rate.
Other arrangements_____

Date:_____ **Patient /Guardian Signature:**_____

Print Name:_____

CAMERON PARK
PHYSICAL
THERAPY
CENTER
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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

The Healthcare Insurance Portability and Accountability act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are

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kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protect health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

I understand and have been provided, (see brochure at front desk), with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. If I have any further questions in regards to the Privacy Practices I can contact the privacy officer.

I understand that CPPT, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CPPT, Inc reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CPPT, Inc change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

Ok to speak with:_____

I understand that as part of CPPT, Inc treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax.
I fully understand and accept the terms of this consent

_____ _____

Patient/ Guardian Signature **Date**

I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as indicated: Date:_____ Initials:_____:Reason:_____

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Past Medical History Form

*Name:*_____ *Date* _____

Are you presently working? Yes No

*How many days per week do you exercise?*_____*Describe the exercise:*_____

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Check which one applies to your condition:

( ) *Motor vehicle accident* ( ) *Work-Related injury* ( ) *Injury related to falling*
( ) *Recurrence of previous injury* ( ) *Injury related to lifting* ( ) *Cause unknown*
( ) *Athletic/Recreational injury* ( ) *Other:*

Have you ever had these symptoms before? *Yes* *No*

Have you had a related surgery? *Yes* *No*

Do you have or have had any of the following:

Pacemaker	*Yes*	*No*	*Unusual Headache*	*Yes*	*No*
Chest Pain/Angina	*Yes*	*No*	*Osteoporosis*	*Yes*	*No*
Heart Disease/Attack	*Yes*	*No*	*Hernia*	*Yes*	*No*
High Blood Pressure	*Yes*	*No*	*Seizures*	*Yes*	*No*
Cancer/Tumor	*Yes*	*No*	*Metal Implants*	*Yes*	*No*
Kidney Problems	*Yes*	*No*	*Dizziness/Fainting*	*Yes*	*No*
Stroke	*Yes*	*No*	*Fracture*	*Yes*	*No*
Bowel/Bladder Abnormalities	*Yes*	*No*	*Surgeries*	*Yes*	*No*
Pregnancy	*Yes*	*No*	*Skin Abnormalities*	*Yes*	*No*
Asthma/Breathing Difficulties	*Yes*	*No*	*Nausea/Vomiting*	*Yes*	*No*
Liver/Gallbladder Problems	*Yes*	*No*	*Ringing in ears*	*Yes*	*No*
Hypoglycemia /Diabetes	*Yes*	*No*	*Loss in Balance*	*Yes*	*No*
Osteoarthritis/Rheumatoid/	*Yes*	*No*			
Rhuematic Arthritis	*Yes*	*No*	*Difficulty in Walking*	*Yes*	*No*
AIDS/HIV	*Yes*	*No*	*Smoking*	*Yes*	*No*
Sensitivity to heat/cold	*Yes*	*No*	*Other*_____	*Yes*	*No*

*If you answered **Yes** to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.*

_____
_____

Do you have any allergies to medication(s) or latex? *Yes* *No*
If yes, please list your allergies: _____

Are you presently taking any medications? *Yes* *No*
If yes, please list what medications and for what condition:

_____
_____
_____

Other Clinical Tests

Within the past year have you had any of the following tests?

(Please circle all that apply)

Angiogram	*EEG (electroencephalogram)*	*Pulmonary function test*
Arthroscopy	*EKG (electrocardiogram)*	*Spinal Tap*
Biopsy	*EMG (electromyogram)*	*Stress Test*
Ultrasound	*Bone Scan*	*MRI*
X Ray	*CT Scan*	*Myelogram*
Venous Doppler Test		

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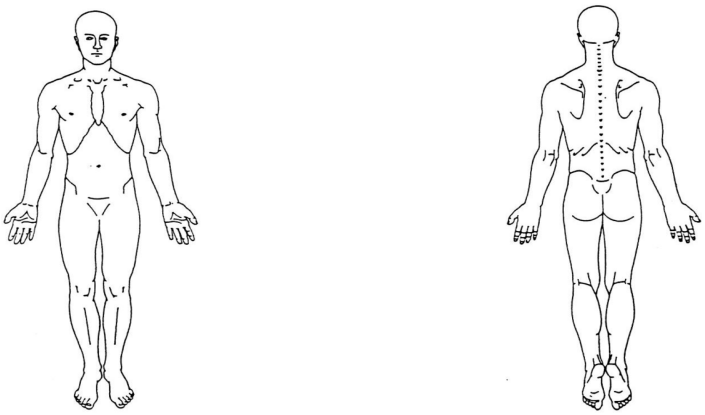
We may request from your physician any reports indicated above and other information that would be helpful in the course of your treatment*

Patient Symptoms Drawing

Please draw on the body where you feel your pain or problems:



Please indicate what kind of symptoms you are having, circle all that apply:

Tingling	*Numbness*	*Sharp*	*Dull*
Ache	*Tight*	*Weak*	*Dizzy*

Please indicate Yes or No:

Yes ***No*** *Have you ever taken steroid medication such as cortisone?*

Yes ***No*** *Have you ever been placed in a cast, splint, ace wrap, or sling for this injury?*

Yes ***No*** *Are you currently being treated or have been treated in the current year by any other physical therapist, Home Health, massage therapist, podiatrist, or chiropractor?* ***If yes, please circle which one.***

If Physical Therapy: how many visits used in the current year? _____

If Home Health: Discharge Date: _____ discharge report required.

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