Pleasanton Physical Therapy Services Inc.
Back on Track Physical Therapy
"Physical Therapy That's Right for You"
backontrack-pt.com

# CONSENT FORM

The following is a list of modalities and procedures that may be used during the course of your physical therapy. At your initial evaluation, your physical therapist will discuss your treatment options and create some goals with you.

Evaluation
Heat
Ice
Electrical Stimulation
Massage/Muscle Release Techniques
Postural Training
Functional Training
*(Body Mechanics, Activities of Daily Living)*

Cold Laser
Cupping
Joint Mobilization
SASTM/Rock Blade Certified
Muscle Stretching
Traction
Therapeutic Exercises
Iontophoresis
Biofeedback Training
Pain Eraser

**Consent for Treatment**

I give my consent for treatment by the health care professional staff of Back on Track Physical Therapy and Pleasanton Physical Therapy to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and/or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Back on Track/ Pleasanton Physical Therapy Services. Furthermore, I understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication, and no guarantee or assurance has been made as to the result of treatment.

Patient Signature:_____ Date: _____

Therapist Signature:_____ Date: _____

# Informed Consent for Physical Therapy Services

_____ *Initial Here*

**Physical Therapy**: The purpose of physical therapy is to treat disease, injury, and disability by use of rehabilitative procedures, and to aid the patient in achieving their maximum potential and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

_____ *Initial Here*

**Informed Consent for Treatment**: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my conditions. I will notify my practitioner if I am pregnant or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

_____ *Initial Here*

**Potential Benefits**: Benefits may include an improvement in my symptoms and increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

_____ *Initial Here*

**Potential Risks**: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy; if it does not subside in 24 hours, I agree to contact my physical therapist.

_____ *Initial Here*

**No Warranty**: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with his/her opinions regarding potential results of physical therapy for my condition and will discuss treatment options with me before I consent to treatment.

_____ *Initial Here*

**Insurance**: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Pleasanton Physical Therapy/Back on Track Physical Therapy will bill my insurance on my behalf. I am responsible for paying any deductible, co-insurance, and/or payment due at the time of service.

I may elect to pay out of pocket for physical therapy services. For patients without insurance or those who elect to pay out of pocket, a discounted "cash rate" of $150 for the initial evaluation and $100 for follow-up appointments will apply. Payments will be due at the time of service.

_____ *Initial Here*

***Cancellation Policy*: "In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hour notice so that we can offer my appointment to patients waiting on the standby list. If I fail to give 24-hour notice of a cancellation, I understand I will be subject to a $75.00 missed appointment fee."**

I have read the above information and I consent to a physical therapy evaluation and treatment. My signature below acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Print Name of Patient  Patient Signature and Date

Pleasanton Physical Therapy Services Inc.
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| Patient Information | | Employment Information | |
|---|---|---|---|
| Name: | | Name of Employer: | |
| SSN: | DOB: | Occupation/Position: | |
| Age: | Sex: | Work Phone: | |
| Height: | Weight: | Employer Address: | |
| Address: | | **Emergency Contact Information** | |
| | | Name: | Relationship: |
| Home Phone: | | Phone: | |
| Cell Phone: | | **Physician Information** | |
| Email: | | Referring MD: | Phone: |
| How did you hear about us? | | PCP: | Phone: |

Pain Rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

*No Pain* *Severe*

**Current Condition(s)/Chief Complaints:**

Describe the problem(s) for which you seek physical therapy: _____
What are your goals for physical therapy: _____
How are you taking care of the problem: _____
What makes the problem better: _____
What makes the problem worse: _____

Have you fallen in the past 2 years? Please Circle: **YES / NO**.
**If yes, please fill out Fall Efficacy Scale below:**
***FALL EFFICACY SCALE:*** One a scale from 1 to 10 with 1 being very confident and 10 being NOT confident at all, how confident are you that you can perform the following activities without falling:

| Activity | Score |
|---|---|
| Taking a bath or shower | |
| Reaching into cabinet or closet | |
| Walking around the house | |
| Preparing meals, not requiring carrying heavy/hot objects | |
| Getting in and out of bed | |
| Answering the door or telephone | |
| Getting in and out of a chair | |
| Getting dressed or undressed | |
| Personal Grooming (Ex. Washing your face) | |
| Getting on and off toilet | |
| **Total Score:** | |

**Medical/Surgical History:**
Circle all that apply

| | | | | | |
|---|---|---|---|---|---|
| Pacemaker | YES | NO | Parkinson's Disease | YES | NO |
| Broken Bones/ Fractures | YES | NO | Seizures/ Epilepsy | YES | NO |
| Osteoporosis | YES | NO | Arthritis | YES | NO |
| Blood Disorders | YES | NO | Cancer | YES | NO |
| Hypoglycemia | YES | NO | Recent Unexplained Change in Weight | YES | NO |
| Depression | YES | NO | Thyroid Problems | YES | NO |
| Heart Problems | YES | NO | Infectious Disease | YES | NO |
| High Blood Pressure | YES | NO | Circulation/Vascular Problems | YES | NO |
| Lung Problems | YES | NO | Kidney Problems | YES | NO |
| Stroke | YES | NO | Ulcers/Stomach Problems | YES | NO |
| Diabetes/High Blood Sugar | YES | NO | **For Women:** Complicated Pregnancy Delivery | YES | NO |
| **For Men**: Prostate Disease | YES | NO | **For Women:** Currently Pregnant | YES | NO |
| Past Surgical History: | YES | NO | | | |

***Documentation of current medication is mandatory***.
Patient: Please list all current medication with dosages (Any prescription, over the counter, herbals, vitamins/mineral/dietary nutritional supplements.)
**If you have a list, please provide a copy at the time of your evaluation and initial here: _____**

| Medication | Dosage | Reason for taking: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*Request additional sheet up front if more space is need.*

**I hereby give my lifetime authorization for payment of insurance benefits to be made directly to Back On Track Physical Therapy/Pleasanton Physical Therapy and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize Back on Track Physical Therapy/Pleasanton Physical Therapy to release all information necessary to secure the payments of benefits. I further agree that a photocopy or a facsimile of the agreement is valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to Back on Track Physical Therapy/Pleasanton Physical Therapy. I consent to have Back on Track Physical Therapy/Pleasanton Physical Therapy and/or its affiliates provide the treatment and care prescribed by my physicians. I understand that this consent may be revoked by me at any time.**

**Patient/Parent/Guardian Signature:** **Date:**

American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9077

# INITIAL HEALTH STATUS

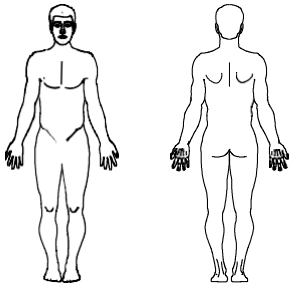
PT OT ST AT Fax: 877.248.2746

Patient Name_____ Subscriber ID #_____ Primary Language_____

**Describe Your Current Problem and How It Began**_____

**Onset date/Surgery date**_____

Indicate below where you have pain or other symptoms



**Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

**How often are your symptoms present?**

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

**Describe the nature of your pain:**

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

**How is your condition changing?**

☐ Getting Better ☐ Not Changing ☐ Getting Worse

**Current complaint (how you feel today):**

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

**In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?**

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**Check if you have difficulty:** ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

**What is your most effective learning method:** ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

**In general would you say your overall health right now is:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Have you had x-rays, MRI, CT Scan for your area(s) of complaint?** ☐ Yes ☐ No

**Date(s) taken**_____ **What areas were taken?**_____

**Please check all of the following that apply to you:**

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)_____
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Other Health Problems (Explain)_____

☐ Numbness (Location)_____
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Current Medications_____

**Who have you seen for your condition before today?** ☐ No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____

☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

**What is your occupation?**_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify thisprovider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needsto be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

**Patient/Responsible Party Signature**_____ **Date**_____