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)
- Telehealth
- 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.
Back on Track Physical Therapy
"Physical Therapy That's Right for You"
backontrack-pt.com

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
Osteoprosis	YES	NO	Arthiritis	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 Pegnancy 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:**

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

1 MD/DO | 2 DC | 3 PT | 4 OT | 5 Both PT and OT | 6 Home Care | 7 ATC | 8 MT | 9 Other ____

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms:

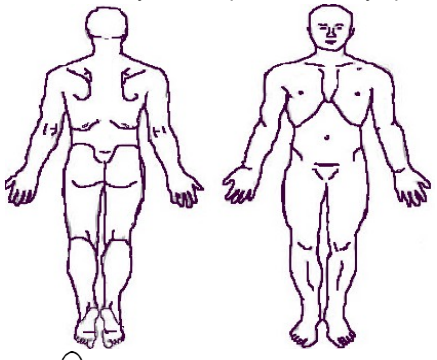
2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____