Action Potential Physical Therapy

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times give one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Action Potential Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Action Potential Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

   Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Action Potential Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **CONSENT FOR EMERGENCY CONTACT INFORMATION**

   Person to contact in case of an emergency:

   _____ _____ _____
   Name Telephone Number Relationship:

   By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

   _____ _____
   Signature of Patient or Legally Responsible Person Date

   _____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Action Potential Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Action Potential Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Action Potential Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that Action Potential Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand Action Potential Physical Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Action Potential Physical Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____]
Spouse/Children:_____

[_____] Other:
_____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:
[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Action Potential Physical Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke? ☐ Yes ☐ No**
Sex: ☐ Male ☐ Female If female, are you currently pregnant? **☐ No ☐ Yes If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

_____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?

☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind? _____

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? ___/___/___to ___/___/__

What was done? _____

☐ Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? _____

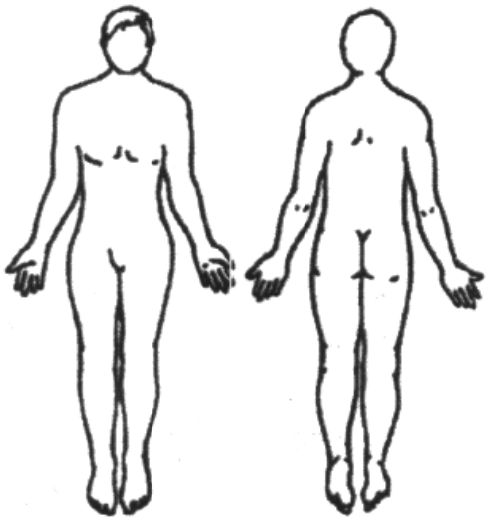
☐ Medications: _____

☐ X-ray _____ ☐ MRI _____ ☐ CT scan _____ ☐ Other: _____

☐ Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***III*** = Numbness



Front Back

Comments: _____

_____

_____

Work Information

Who is your employer? _____

What is your job title/responsibilities? _____

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: _____

- Lift/carry:☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)

  Where to where _____ to _____.

- Repetitive motions related to condition: ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)

- Static positions related to condition (**mod-high**): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ _____

- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ Low Demand ☐ Moderate-High Demand

Comments: _____

Additional Comments: _____

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Drinking or Eating	_Yes _No	Balancing on both feet	_Yes _No
Sleeping Through the Night	_Yes _No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	_Yes _No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	_Yes _No	Lifting	_Yes _No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	_Yes _No	Carrying	_Yes _No
Getting in/out of: chairs, bed, car or bath/shower	_Yes _No	Bending, Kneeling Squatting	_Yes _No
Reaching: overhead, behind back, downward for forward	_Yes _No	Driving a vehicle or ability to use gas/brake pedals	_Yes _No
Gripping, Holding tools or Opening Jars	_Yes _No	Caring for child or adult	_Yes _No
Picking up Small Objects	_Yes _No	Housework / Yard work	_Yes _No
Sitting	_Yes _No	Recreational Activities	_Yes _No
Standing	_Yes _No	Have you fallen more than 1 time in the past year	_Yes _No
Job Related Activities	_Yes _No	Have you fallen and hurt yourself in the past year	_Yes _No

Other:

ACTION POTENTIAL
CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)