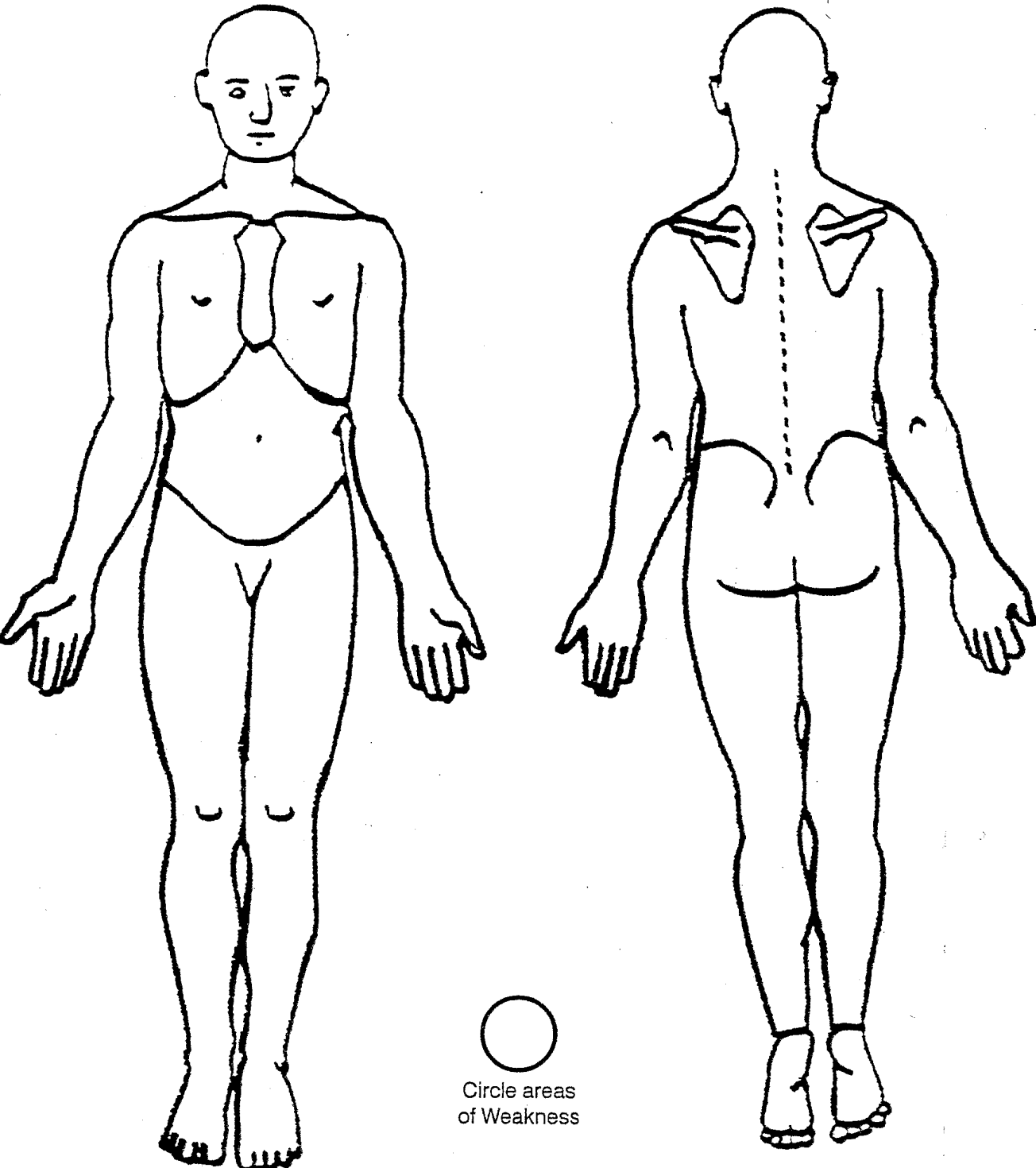
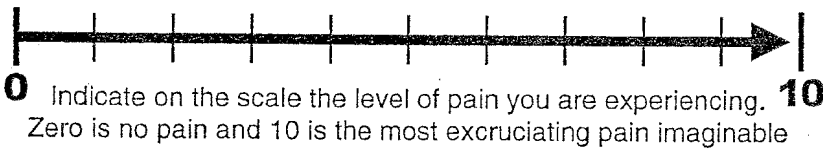


Patient Symptom Drawing



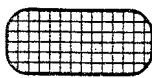
Pain Scale



Use the body diagram above to indicate the location of any of the sensations listed. Mark the areas on the diagram with the symbol that best describes the sensation you feel



Pain or Ache



Swelling or Redness



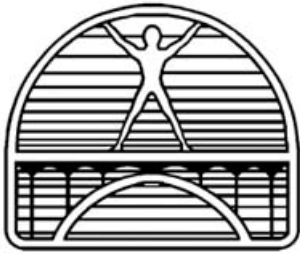
Pins & Needles



Stiffness



Numbness



FOLSOM PHYSICAL THERAPY *and Training Center*

Consent to Treat

Were you injured on the job?	YES	NO
Have you filed a work comp claim?	YES	NO
Were you injured in a motor vehicle accident?	YES	NO
Is this injury involved in litigation?	YES	NO

If you have an attorney, please fill out the following:

Name of Attorney: _____ Phone#: _____

Address: _____

***We do not accept liens against pending legal settlements.**

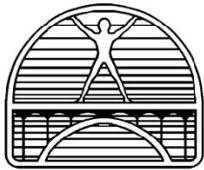
Missed appointments are a loss for everyone. Please notify us as soon as possible if you cannot keep your scheduled appointment. We require **(a minimum) 24-hour cancellation notice** to allow us time to fill your appointment time. **Cancellations or missed appointment (“no shows”) without at least a 24-hour notification are subjected to a \$25.00 fee.**

I, _____, have read and understand that I remain responsible for
(PRINT NAME HERE)

the total amount due to Folsom Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

Signature: _____ Date: _____



FOLSOM PHYSICAL THERAPY
and Training Center
Medical Release Authorization

To Whom It May Concern:

I, _____, hereby give my consent for Folsom Physical Therapy to release my Protected Health Information (PHI) including physical therapy notes, dates of services, and diagnosis codes, to/from the following person(s)/facilities:

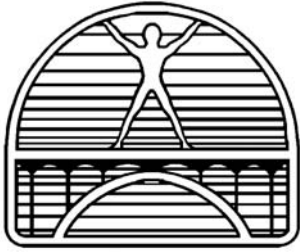
Effective dates: _____ - _____

This authorization may be revoked at any time by delivering a signed Restriction Request Form to our business office at Folsom Physical Therapy.

Sincerely,

Signature

Date



FOLSOM PHYSICAL THERAPY *and Training Center*

Financial Policy

We are committed to providing you the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial payment policy.

Payment is due at the time of service unless special payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa, and MasterCard. We will be happy to process to your insurance claim for reimbursement. However, **it is the patient's responsibility to familiarize themselves with their own insurance policy and understand their terms and coverage thoroughly regarding physical therapy.**

Returned checks and balances older than 30 days may be subjected to additional collection fees and interest. Charges will be made for cancellations or missed appointment ("no shows") without a minimum 24-hour notification.

We will be happy to discuss your questions and concerns relating to your specific physical therapy coverage. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company; we *are not* a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier.
- This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost and care in this area.
- Not all services are covered benefit in all contracts. We suggest you find out if physical therapy is covered under your insurance contract.

We must emphasize that, as physical therapy providers, our relationship is with you, the patient, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions regarding the above information, please do not hesitate to ask us.

I, _____, have read and understand the above Financial Policy.
(PRINT NAME HERE)

(Patient/Guardian)Signature: _____ Date: _____



FOLSOM PHYSICAL THERAPY
and Training Center
HEALTH HISTORY

Yes No

- Osteoporosis
- Diabetes
- Hypertension (High Blood Pressure)
- Heart Disease
- Cancer or Tumors
- Lung Problems
- Stomach Problems
- Kidney or Liver Problems
- Arthritis or other Joint Problems
- Seizures or Nervous Disorders
- Allergies
- Dermatitis or any Skin Problems
- Eye Problems
- Hernias
- Unusual/ Frequent Headaches
- Are there any other health problems not mentioned above? If so please describe:**

- Do you have any family history of any of the above problems? If so, please describe:**

- Are you pregnant?
- Do you have any implants? (i.e. joint replacements or pacemakers)?
- Are you awakened at night?
- Do you ever have uncontrolled leakage of urine, gas, or feces?
- Have you ever taken any medications for longer than a few weeks?
- Have you ever taken any steroid medications such as cortisone?
- Are you currently taking any medications?
- Have you ever been hospitalized?
- Have you ever had surgery?
- Have you ever been placed in a splint, cast, ace wrap or sling?
- Have you ever had to use crutches, canes, a walker, or wheelchair?
- Do you use any shoe lifts, braces, corsets, or supports?
- Are you currently treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, etc.

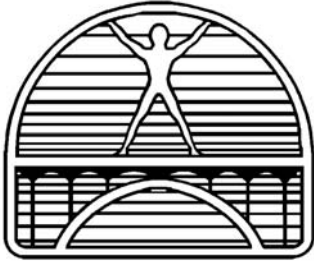
Do you consider your health to be: Excellent, Good, Fair, Poor

Date of Last Physical Exam: _____ Physician: _____

Reason for Today's Visit: _____

Current Physician: _____ Who Recommended you to us? _____

Patient/Guardian Signature: _____ Date: _____



FOLSOM PHYSICAL THERAPY
and Training Center

Privacy Practice Document

- This notice describes how medical information about you, the patient, may be used and disclosed. It also explains how you can get access to this information. **Please review it carefully.**

Our commitment here at *Folsom Physical Therapy* is to serve our patients with professionalism and care, while protecting the privacy and security of all Protected Health Information at all times.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. Examples of such instances are described below:

- We may request from your physician MRI's, X-Rays, operation reports and other information that would be helpful in the course of your treatment.
- We use the services of an independent billing company, and so medical information will be passed along to them for billing and payment purposes.

We, here at *Folsom Physical Therapy*, are committed to obeying all federal, state, and local laws regarding privacy practices. If any other uses or disclosures other than those listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your protected health information, please contact our compliance officer, **Darlene, at (916) 388-8500.**

I, _____, have read and understand the above Notice of Privacy Practices.
(PRINT NAME HERE)

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