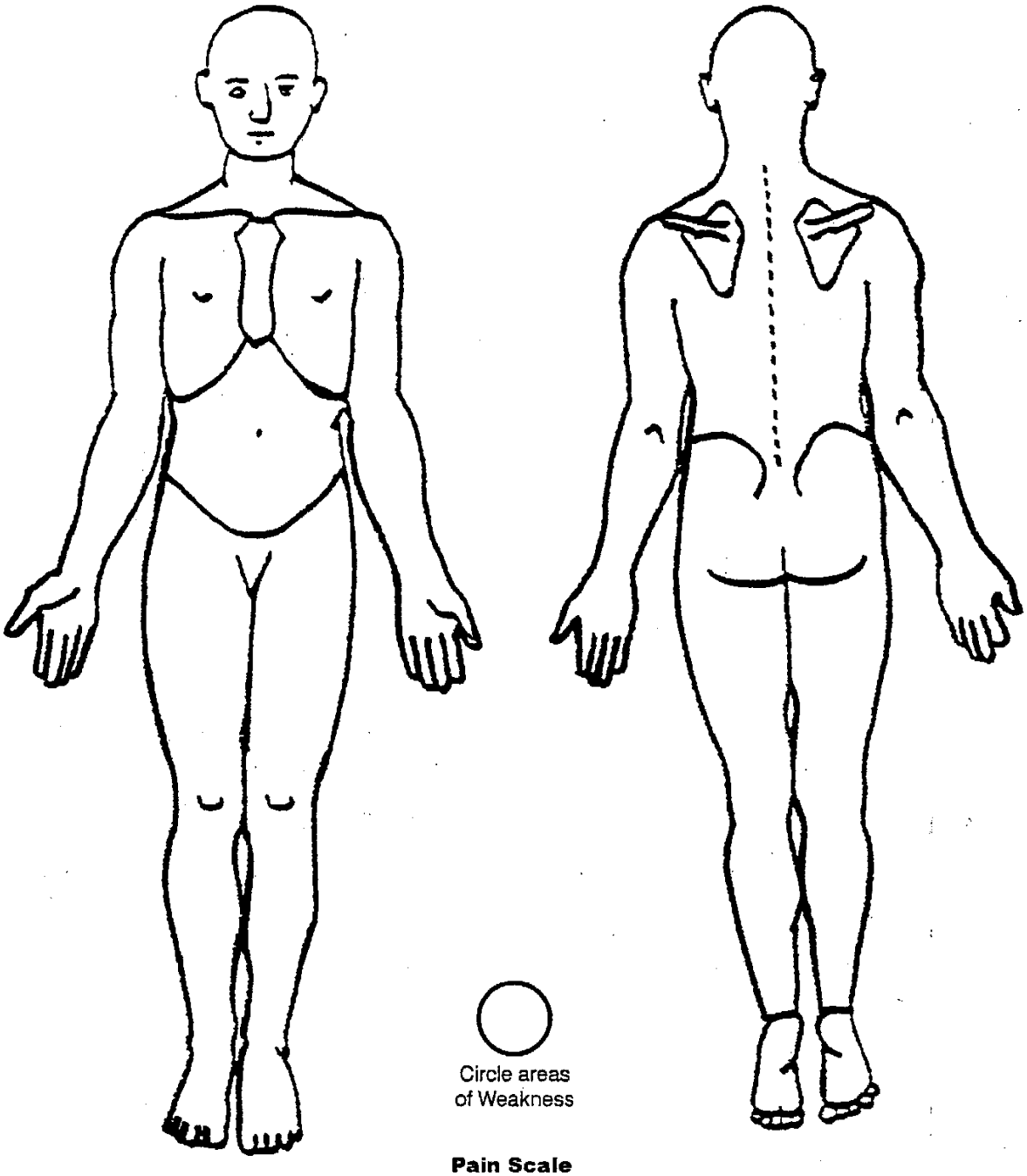
Patient Name: _____ Date: _____

Patient Symptom Drawing



Circle areas of Weakness

Pain Scale

0 Indicate on the scale the level of pain you are experiencing. **10**

Zero is no pain and 10 is the most excruciating pain imaginable

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
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
BMI/ MEDICATION LIST

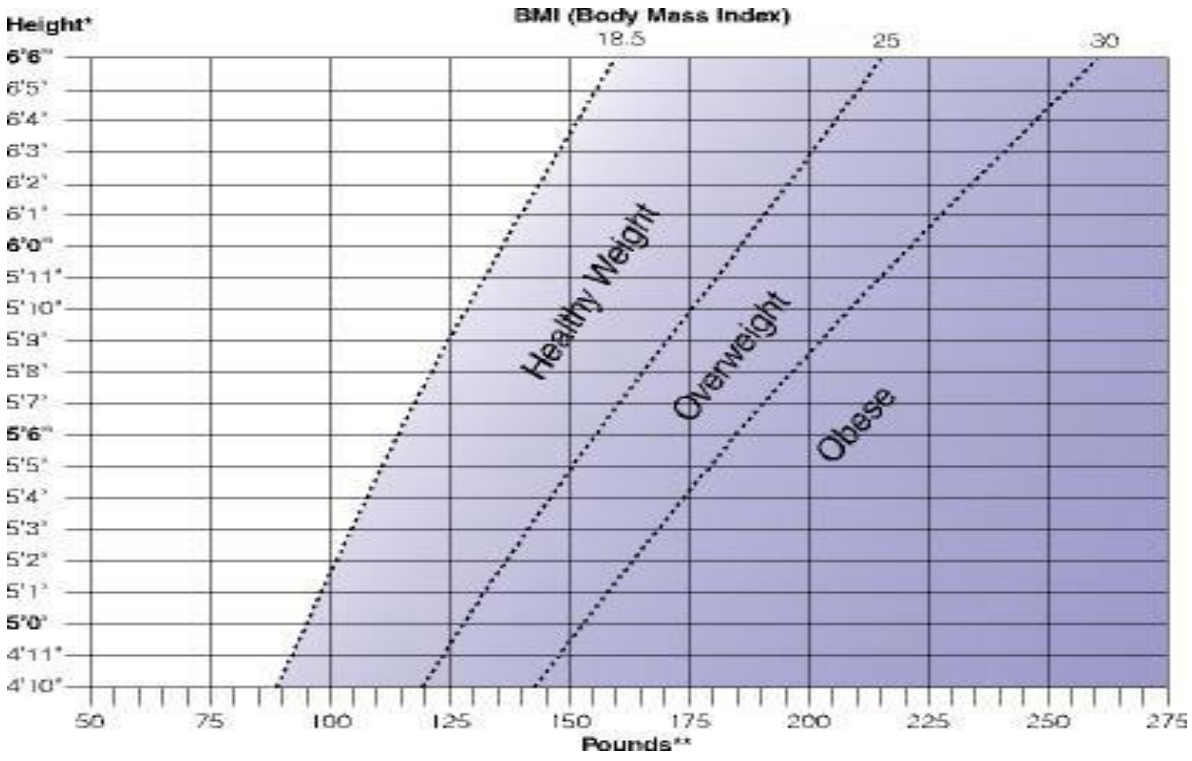
Patient Name: _____ DOB: _____

Patient Medication List

Medication	Dose	Reason	Start Date

Patient BMI

Weight (lbs) _____ **Height _____**



FOLSOM PHYSICAL THERAPY
and Training Center
CONSENT TO TREAT

Please circle Yes or No: (for the current body part/ injury)

Were you injured on the job?	Yes	No
Have you filed a work comp. claim?	Yes	No
Were you involved in a Motor Vehicle Accident?	Yes	No
Is this injury involved in litigation?	Yes	No

***We <u>DO NOT</u> accept liens against pending legal settlements.**

If you have an **Attorney**, please fill out the following:

Name of Attorney: _____

Phone: _____ Fax: _____

Address (include city, state & zip): _____

Have you had any Physical Therapy this year at another clinic? Yes No

If yes, how many visits? _____

Have you had any Chiropractic visits this year? Yes No

If yes, how many visits? _____

<u>Missed Appointments:</u>

Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment in order for us to be able to fill your appointment time. **Cancellations or missed appointments without 24 hour notice are subject to a charge equal to the amount of the appointment to your credit card.**

I, _____, have read and understand that I remain responsible for 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 my 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.

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

FOLSOM PHYSICAL THERAPY
and Training Center
FINANCIAL 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, major credit cards (Visa, MasterCard, etc.) 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.**

The exact cost of our treatment is impossible to predict as the amount billed varies depending on services rendered at each visit. Reimbursements by insurance companies also vary and are predictably less than the billed amount.

In an attempt to help you understand your financial relationship with us, an estimate of the average cost of treatment is as follows:

	Average Billed Amount	Cash Pay Discount
Evaluation	$225.00	$150.00
Regular follow-up	$125.00	$85.00
Extended Follow-up	$200.00	$150.00

The cash pay discount can be applied if arrangements are made **prior** to initiating treatment and paid at the time service is rendered.

Please do not ask us to retroactively alter our business arrangement with you. Once your insurance has been billed it is very difficult to alter the process.

If you have a large deductible it may be in your best interest to have a cash pay arrangement with us. You may also be capable of submitting your receipts to your insurance company for full or partial reimbursement, or the amount paid applied to your deductible. Your ability to do so and the amount recognized by your insurance company will be dependent of your contract with them.

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

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

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

FOLSOM PHYSICAL THERAPY
and Training Center
PRIVACY PRACTICE

- 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) 355-8500**.

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

(Patient/Guardian) **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:

_____, M.D

Effective dates: _____ - end of treatment

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

Sincerely,

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

FOLSOM PHYSICAL THERAPY
and Training Center
FOR PROFIT

➢ FOLSOM PHYSICAL THERAPY IS A FOR PROFIT BUSINESS

AB 1000 allowing consumers to directly access physical therapy services for the lesser of 12 visits or 45 days from the date the services were initiated. This law requires physical therapy practices to inform patients that they are "For Profit" businesses and that the recommendation of treatment will influence their profit.

Please sign below, indicating that Folsom Physical Therapy & Training Center has compiled with this aspect of the law.

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

➢ APPOINTMENT REMINDER WAIVER

I, _____, would like to receive text/email reminders regarding my scheduled appointments at Folsom Physical Therapy. I, the undersigned, give Folsom Physical Therapy permission to send my appointment information to me via text/email. I understand that standard text messaging rates will apply to me. I also understand that I cannot reply to the text/email reminders directly, and that I will need to call Folsom Physical Therapy in order to cancel or reschedule an appointment.

Cell Phone Carrier: _____

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