



INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical therapy involves the use of many different types of physical evaluation and treatment. At Coarsegold Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Coarsegold Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Patient Name

Patient Signature

Date

35324 Highway 41 Suite D, Coarsegold, CA 93614

COARSEGOLD PHYSICAL THERAPY, INC.

35324 Highway 41 Suite D
Coarsegold, CA 93614
559-641-5445

Patient Information

Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____
Employer: _____
Work Phone: _____
Occupation: _____
How did you hear about us? _____

Emergency Contact Information

Name: _____
Phone: _____

Doctor Information

Referring Physician: _____

If Minor or Insured under another person

Name of insured: _____
Date of Birth: _____
(if different from above, please fill out below)
Address: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____



HEALTH QUESTIONNAIRE

	Yes	No	Details of "Yes" Answer
1. What condition are you seeking treatment for? _____			
2. Have you ever had Physical Therapy before?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever had Physical Therapy for this condition?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you had other treatments for this condition?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever had:			
Heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Nerve/Sensation problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble with your vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble with your hearing?	<input type="checkbox"/>	<input type="checkbox"/>	
Other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have any metal implanted in your body?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are you or might you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you currently having any medical tests?	<input type="checkbox"/>	<input type="checkbox"/>	
11. In general, would you say your health is:	Excellent	Very Good	Good Fair Poor
12. What is your pain level?			
0 1 2 3 4 5 6 7 8 9 10			
No pain min min-mod mod mod-severe worst pain ever			



PAYMENT INFORMATION AND CONTRACT

Welcome to Coarsegold Physical Therapy! We would like to take this opportunity to review our billing and payment procedures with you. We will happily discuss your proposed care and answer any questions you may have relating to your treatment and insurance coverage before we begin therapy. We are committed to help you receive the maximum amount of benefit from any insurance coverage you have. Please take your time in reading through our billing policies below. If you have any questions about your financial obligations for your care, please let us know so that we may help you.

PRIVATE INSURANCE

1. You agree to be responsible for all of our charges, even if you have insurance. If you have any questions as to our fees for your care, please let us know before continuing your treatments.
2. You understand that Coarsegold P.T. will not accept the responsibility for collecting your insurance claim, or negotiating a settlement for you, if a dispute arises between you and your insurance company. If such a dispute should arise, you agree to pay your outstanding balance to Coarsegold P.T. and then pursue the reimbursement from your insurance company thereafter.
3. You agree to pay any portion of your bill not covered by your insurance upon receiving your statements each month.

If you find that you are unable to keep an appointment, please notify us at least 24 hours in advance.

Medical Supplies. Some insurance carriers cover durable medical equipment, but many do not, nor do they pay for routine medical supplies. Therefore, we will also ask you to pay for any special order items in advance. We will inform you of the cost of any medical supplies and will bill you accordingly if you agree to use them.

I have read, understand and agree to the above payment procedures. I have received a copy of this contract, and agree that a photo static or facsimile copy of this document is as valid as the original.

Patient/Guarantor

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment for your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Company. For example, information on the services you received may be used to support budgeting and financial law-enforcement investigations, and to comply with government mandated reporting.

Law Enforcement. Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Your Health Information Rights.

You have certain rights under federal privacy standards. These include:

- * The rights to request restrictions on the use and disclosure of your health information

- * The right to receive confidential communications concerning your medical condition and treatment
- * The right to inspect and copy your health information
- * The right to amend and/or submit corrections to your health information
- * The right to receive any accounting of how and to whom your health information had been disclosed
- * The right to receive an printed copy of this notice

Our Health Information Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Our Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

Requests to Inspect Protected Health Information

As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form request access to your records by contracting the Company's Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have violated, you can contact the Company by sending a letter outlining your concerns to:

Privacy Officer
Coarsegold Physical Therapy, Inc.
35324 Highway 41 Ste D
Coarsegold, CA 93614

You may also file a written complaint with the Office of Civil Rights.

Effective Date: January 1, 2011



Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to request that we restrict how PHI about you is used or disclosed.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Signing this sheet also indicates that you have received a copy of our Notice of Privacy Practices on the date indicated.

If you have any questions regarding the information set forth in our Notice of Privacy Practices, please contact William Lapham, Privacy Officer at 559-641-5445.

I authorize Coarsegold Physical Therapy, Inc. to release my medical information to the following individual(s) (family, relative, friend, etc.)

Name_____	Relation_____
Name_____	Relation_____
Name_____	Relation_____

_____ Patient or Representative Signature	_____ Relationship If Other Than Patient
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Printed Patient Name

Date

Witness/Employee