Treatment Consent & Liability Waiver

I understand I have been referred or have chosen to refer myself for rehabilitative treatment/physical therapy at CHOICE Physical Therapy & Wellness, Inc. CHOICE Physical Therapy & Wellness has or will describe for me my individual treatment plan. I understand I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have CHOICE Physical Therapy & Wellness (CPTW) provide treatment and care as prescribed by my physician and/ or recommended by my therapist.

Management shall not be liable for any damages arising from personal injuries or damages and does release CPTW owners, employees, and agents from any and all claims, demands, rights or cause of action, present or future, resulting from the patient and/or patient's guest's use of the facilities and equipment.

I fully understand that I am giving consent to treat and waiving my liability as stated above. I also fully agree to comply with the cancellation and tardy policies.

Patient signature _____Date _____

(Must be signed by parent/guardian if patient is under 18 years of age)

Assignment of Benefits

I hereby instruct and direct my current insurance company to pay by check made out and mailed to CHOICE Physical Therapy & Wellness. If my/this current policy prohibits direct payments to providers, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agrees to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

I authorize the following:

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical r other information pertinent to my case to any insurance company, adjusters, or attorneys involved in this case for the purpose of processing claims and securing payments of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize CHOICE Physical Therapy & Wellness to deposit checks made in my name.
- I authorize CHOICE Physical Therapy & Wellness to initiate a complaint to the Insurance Commission for any reason on my behalf.
- I understand I am financially responsible for all charges whether or not paid by my insurance.

Patient signature _____Date _____

(Must be signed by parent/guardian if patient is under 18 years of age)

Choice PT Officer's Initials:CAV_____
Date:4/10/2018_____

Second Party's Initials: _____
Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

As part of my health care, **Choice Physical Therapy & Wellness, Inc.** (The Company) 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 The Company's 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 surgical information 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 The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company 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 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 The Company 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.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Choice Physical Therapy & Wellness, Inc. and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013

Marketing Authorization Form

1. Authorizing marketing communication from this practice means I may:
   A. Receive treatment communications concerning treatment alternatives or other health related products or services
   B. Be contacted for appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest me.

***I understand that I have the right to "opt out" of receiving such communications.**
***I understand that this practice may receive financial remuneration for communications.**

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:
   - ❑ I wish to receive Marketing Communications from this Practice Only
   - ❑ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.
   - ❑ I DO NOT wish to receive ANY Marketing Communications

Patient Signature: _____ Date: _____
Patient Email:_____

Communication that encourages you to use our services is considered marketing. If we intend to use, or sell PHI for personal gain or commercial advantage, we must first obtain written authorization. Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications from a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. We MAY receive financial remuneration from a third party due to marketing. HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications. In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.

Cancellation / No Show Policy

We take your time very seriously and understand that circumstances arise that may result in you being required to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Failure to give us the appropriate 24 hour notice will result in a **$50.00 charge** being assessed to your account. Our clinicians want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment or fails to give adequate notice, another patient loses an opportunity to be seen and progress towards his or her goals.

Patient signature _____Date _____
(Must be signed by parent/guardian if patient is under 18 years of age)

Choice PT Officer's Initials:CAV_____
Date:4/10/2018_____

Second Party's Initials:_____
Date:_____

Name: _____ **Date:**_____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age:_____ **Height:** _____ **Weight:**_____

Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**

Do you smoke? Yes No **Do you have a pacemaker? Yes No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

Choice PT Officer's Initials:CAV_____
Date:4/10/2018_____

Second Party's Initials:_____
Date:_____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

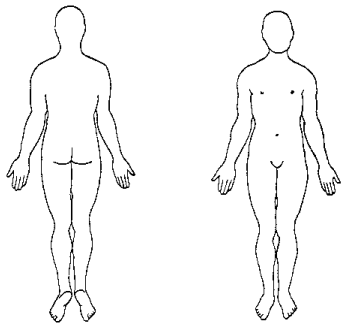
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

1. Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1._____2. _____3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1._____2._____3._____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

1. On the 0-10 scale provided below, circle your **average pain level** at this time.

0 1 2 3 4 5 6 7 8 9 10

Best ——————————————————— **Worst**

2. On the 0%-100% scale provided below, circle the **percent of normal function** at which you are currently able to perform. This includes: work performance, activity at home, sports, socially with friends, etc.

Best ——————————————————— **Worst**

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

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Date:4/10/2018_____

Second Party's Initials:_____
Date:_____