# Function Ability Physical Therapy

Specializing in Women's Health

**Debora Chassé DPT, WCS, CLT-LANA**

**Welcome to Function Ability Physical Therapy.**
**It is our hope that we can assist you with your current and future health concerns. Our focus is: health improvement, maintenance, prevention, and education. Any current health problems may be indicators of underlying imbalances. Part of our responsibility will be to explore your musculoskeletal health status, assess the possible root cause for your complaints and to advise you on physical therapy to ensure optimal well being.**
**During the course of your examination and treatments, please feel free to comment, ask questions and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health.**
**Together, we can form a team on the side of a healthy future.**

Name: _____ Birth Date: _____/_____/_____

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

Address: _____

Email: _____

Referring Physician:_____ Phone:(____)_____

## Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for

## Function Ability Physical Therapy

to administer medical care and treatment to _____, which is considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian Signature:_____ Date:_____

414 Tennessee St., Suite W
Redlands, CA 92373 (909) 307-0155

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## Patient Record of Disclosures

The HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information.

### Release of Information

I give permission to Function Ability Physical Therapy to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality assurance purposes. This information can be released through electronic interchange, telephone, facsimile, and mail.

I understand that I may request restriction regarding the use of my health information to revoke this consent by following the procedures outlined in the Notice of Privacy Policies. However, Function Ability Physical Therapy is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulation.

**Note: Uses and disclosures for treatment, payment, operations (TPO) information may be permitted without prior consent in an emergency.**

### Permission for Messages

I give permission to Function Ability Physical Therapy to leave messages concerning my treatment:

☐On my voicemail or answering machine at home
☐On my voicemail on my cell phone
☐On my voicemail at my work
☐With another person (Name/Phone):_____

I give permission to Function Ability Physical Therapy to leave messages concerning my appointment times:

☐On my voicemail or answering machine at home
☐On my voicemail on my cell phone
☐On my voicemail at my work
☐With another person (Name/Phone):_____

I have read and understand the above policies

Patient Name: _____
Patient/Guardian Signature:_____ Date:_____

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## Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Function Ability Physical Therapy Legal Duty

Function Ability Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Function Ability Physical Therapy may use your personal health information to contact you to provide appointments or information about treatment or other health-related benefits that could be of interest to you.

Function Ability Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

Function Ability Physical Therapy may change its policy at any time. When changes are made, a new Notice of Privacy Policies will be posted in the waiting room and will be given to all current patients at their next visits. You may also request an updated copy of our Notice of Privacy Policies at any time.

### Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Function Ability Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

### Concerns and Complaints

If you are concerned that Function Ability Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Patient Name: _____

Patient/Guardian Signature:_____ Date:_____

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## Attendance and Cancellation Policy

We are glad you have chosen Function Ability Physical Therapy to provide you with high quality individualized medical care. We value you and the time specifically reserved for you, therefore we never over schedule. We take this subject seriously at our clinic because coming consistently to physical therapy can make the difference between whether you succeed in your treatment or not.

Thank you for your compliance to the following policies regarding cancellation and no-shows.

- A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advanced notice. If this occurs, the patient will be required to pay a $50.00 fee.
- A "no show" occurs when a patient misses an appointment without canceling in an adequate manner. If this occurs that patient will be required to pay a $50.00 fee.
- A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no show." This includes arriving 15 minutes or later after your scheduled appointment time. If this occurs the patient will be required to pay a $25.00 fee.
- At three occurrences of any of the above-mentioned circumstances you and your physician will be notified of your discharge from Function Ability Physical Therapy's care.
- These charges are not covered by your insurance but will have to be paid by you personally prior to your next visit with your therapist.

## Payment Policy

We are non-contracted with all insurance companies and are considered as an out-of-network service provider. We cannot guarantee that your insurance company will pay for our services.

Regarding insurance companies who authorize a contract under special circumstances:

- I authorize payment of benefit to be made directly to Function Ability Physical Therapy for services rendered. I guarantee that I will immediately reimburse Function Ability Physical Therapy for any benefits assigned to me.
- I will be responsible for deductible amounts, co-insurance percentages, and the remaining balance not paid by the insurance company. Therefore, the entire balance on the account remains always the sole responsibility of the patient.

Please review your insurance policy.

Regarding cash patients, the patient is ultimately responsible for payment of services rendered to the patient.

- I expressly guarantee payment of this account and agree to pay any charges left unpaid, in whole or in print.

Patient Name: _____

Patient/Guardian Signature:_____ Date:_____

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## Direct Physical Therapy Treatment Services

Pursuant to Section 2620 of the California Code of Regulations,

"You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist."
*(Added by Stats. 2013, Ch. 620, Sec. 4. Effective January 1, 2014.)*

Please note: These conditions do not apply to a physical therapist when he or she is only providing wellness physical therapy services to a patient.

Patient Name: _____
Patient/Guardian Signature:_____ Date:_____

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## Optional Research Consent Form

**Function Ability Physical Therapy is dedicated to continuing education in effective physical therapy treatment techniques and success rates. Please carefully review the following components of our research materials (video, photo, and case study data) and decide if you would be willing to participate in future studies by allowing us to use your medical information. Thank you.**

Participant's name: (print)

_____

I hereby authorize Function Ability Physical Therapy (FAPT) to take photographs and/or videos of me at the clinic. I authorize FAPT to use and publish the photographs and/or videos taken of me for their printed materials, website, lecture presentations, training courses, and other educational purposes. I acknowledge that FAPT may use such photographs and/or videos of me with or without my name for purposes such as publicity, education, illustration, advertising, and web content.

I further agree that my participation in any photographs and/or videos produced by FAPT confers upon me no rights of ownership whatsoever. I acknowledge that since my participation in printed materials and web pages produced by FAPT is voluntary, I will receive no financial compensation. I release FAPT, its contractors, and its employees from liability for any claims by me or any third party in connection with my participation.

I give permission to Function Ability Physical Therapy to use my medical information for the purpose of research and case studies in order to educate colleagues about effective physical therapy techniques. I acknowledge that my name and identity will remain private and anonymous. I understand that my participation in any research conducted by FAPT is my completely voluntary will not affect my treatment or patient status.

Please check the following boxes indicating your consent:

Photos ☐ Videos ☐ Case Studies ☐

Signature: _____ Date: _____

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Patient's Name:_____

## Confidential Health and Lifestyle Questionnaire

Please complete this questionnaire with care. Your answers will help us to determine the most effective care for you. Please print. Thank you.

Height:_____ Weight:_____

Are you satisfied with your present weight? Yes_____ No_____
Have you ever had a weight problem? Yes_____ No_____
Do you exercise regularly? Yes_____ No_____ How often?_____

What type of exercise program?_____

What are the things you find stressful? _____

What things do you do for relaxation? _____

List your hobbies?_____

How many hours of sleep do you get per night?_____

What are your health concerns, in order of importance to you?

1._____

2._____

3._____

4._____

5._____

If there is a specific condition, how long has it been occurring?_____

Have you had similar problems before? Yes___ No____

Do you have relatives with similar problems? Yes___ No____

What do you feel the causes of your health problems are?_____

_____

When did you last feel well?_____

Severity of Condition: (0 – no pain to 10 – unbearable pain)_____

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Patient's Name:_____

## Confidential Health and Lifestyle Questionnaire (cont'd)

**Past Accidents/Injuries:**

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

**Past Surgeries:**

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

**Past Hospitalizations:**

Description: _____ Date: _____

Description: _____ Date: _____

**Past Infections/Major Illnesses:**

Description: _____ Date: _____

Description: _____ Date: _____

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Patient's Name:_____

## Confidential Health and Lifestyle Questionnaire (cont'd)

**Past Conditions and Diseases** (Please Circle)

| | | |
|---|---|---|
| High Blood Pressure | Hernia | Sensitivity to heat/ice |
| Seizures | Heart Attack | Diabetes |
| Heart Disease | Dizzy Spells | Balance Problems |
| Headaches | Headaches | Pacemaker |
| Kidney Problems | Pregnant | Nervous Disorder |
| Hearing Problems | Cancer | Vision Problems |
| Metal Implants | Celiac's Disease | Loss of Consciousness |

Other _____

**Medications**

Name/Description: _____

Name/Description: _____

Name/Description: _____

Name/Description: _____

**Allergies** - Please list any allergies

_____

_____

_____

**Tests/Exams**

Have you had any X-rays, MRIs or full body scans in the last 3 years? Yes___ No___

What did the images reveal?_____

Date of last pelvic/prostate exam: _____ Results:_____

Date of last dexa scan/ bone density test: _____ Results: _____

Date and results of any other recent tests:_____

_____

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Patient's Name:_____

## Confidential Health and Lifestyle Questionnaire (cont'd)

**Other**

Do you have leakage problems or urgency to get to a bathroom?_____

Are you constipated? Yes___ No___ Number of bowel movements per day?_____

Do you drink coffee, black tea or soda?_____ Per day?_____

Do you smoke? Yes___ No___ How long?_____ Per Day?_____

Do you drink alcohol? Yes___ No___ Daily Amount: _____Weekly Amount:_____

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If you are **female**, please complete the following.

Date of last mammogram: _____ Results: _____

Date of last menstrual cycle: _____

How many pregnancies have you had? _____ How many deliveries?_____

Were there any complications?_____

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Patient's Name:_____

## Confidential Health and Lifestyle Questionnaire (cont'd)

**Family Medical History** - If there is a history of any of the following in your family, please check and state the relationship of the family member.

| | | |
|---|---|---|
| Alcoholism | Celiac | Mental Disease |
| Allergies | Colitis | Muscular Dystrophy |
| Arteriosclerosis | Depression | Multiple Sclerosis |
| Arthritis | Diabetes | Schizophrenia |
| Asthma | Epilepsy | Stomach Ulcers |
| Bed Wetting | Heart Disease | Stroke |
| Candida Albicans | Hyperactivity | Tuberculosis |
| Cancer | Kidney Disease | Yeast Infections |
| Cataracts | Learning Disability | Venereal disease |

Is there any other information you would like us to know about:

_____

_____

_____

_____

_____

_____

Your Goals for Physical Therapy:

_____

_____

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