CONDITIONS & CONSENT FOR PHYSICAL THERAPY

I understand that I am a patient of Theresa Plasencia PT,MPT who is an independent Physical Therapy practitioner at Theresa Plasencia Physical Therapy. My care is the exclusive responsibility of Theresa Plasencia, PT ,MPT , not of any other practitioners who also may practice at this location.

Cooperation with treatment:
In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50.00.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: I may include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
I authorize the release of my medical records to the following physicians/primary care provider or insurance company;

_____

_____

_____

Financial and insurance responsibilities:
I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment.

_____ _____

Print Name Date

_____ _____

Patient or guardian signature Therapist signature / Date

Plasencia Physical Therapy
NEW PATIENT INFORMATION **Today's Date:**

Patient Name: _____ **Date of Birth:** _____

Address _____

_____

EMAIL Address: _____

Home Phone _____Work Phone_____

Cell Phone _____Preferred Phone: (circle) Home / Work / Cell

Emergency Contact _____ Ph# _____

Gender: M / F / Transgender
Relationship status (circle): Married Partnered Single Divorced Other

Occupation:_____

Referred by: _____

Physician's clinic address: _____

Physician's clinic phone: _____Fax: _____

Have written Rx? _____ Problem requiring therapy _____

_____

INSURANCE INFORMATION:

Insurance Co Name: _____

Insured's Name:_____ Date of Birth of Insured:_____

Relationship to above client: _____ Phone:_____

Policy ID #_____ Group #_____

Have you contacted your ins. co. to verify benefits ?_____ Deductible ?_____Co-pay?_____

Second Ins. Co Name:_____Policy ID/Group #s_____

_____

Who can I thank for referring you?_____
Address _____
Phone _____Fax _____