ONSITE
PHYSICAL THERAPY
SERVICES OF HERSHEY

Consent for Physical Therapy Services from

Onsite Physical Therapy Services of Hershey ("OPTSH")

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. OPTSH does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. For that reason, it is very important to communicate with your treating physical therapist throughout your treatment. You may also request that alternative treatments be provided or recommended when appropriate.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I also authorize the release of my medical information to appropriate third parties, as required by law.

_____

Printed Name

_____ _____

Signature **Date**

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Practice Policies, Assignment, and Authorization

All patients must recognize that they are responsible for the charges incurred for physical therapy.

Missed appointments are a loss for everyone. Therefore, we require that you notify us 24 hours in advance if you are unable to attend a scheduled appointment. Cancellations without adequate notice cannot be filled and take valuable time from other patients, thus they are subject to a $50 late cancel fee. Checks that are returned for any reason are subject to a $20 service fee.

By signing below, you are hereby authorizing payment directly to OPTSH, LLC such sums as may be due and owing for services rendered, both by reason of accident of illness, and by reason of any other bills that are due, notwithstanding any settlement, judgment , or verdict on my behalf as may be necessary to adequately protect said practice. This is to act as an assignment of rights and benefits to the extent of the practice's services provided. I hereby assign and transfer to this practice any and all causes of action that I might have or that might exist in my favor against such company and authorize this practice to compromise, settle, or otherwise resolve said claim or cause of action as they see fit. I understand that I remain personally responsible for the amounts due this practice for their services. I further understand and agree that this assignment and authorization does not constitute any consideration for the practice to await payments and they may demand payments from me immediately upon rendering services at their option. I authorize this practice to release any information pertinent to my case to any adjuster or attorney to facilitate collection under this assignment and authorization.

_____

Printed Name

_____ _____

Signature **Date**

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

The Healthcare Insurance Portability and Accountability act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. We are required by law to maintain the privacy of your protect health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

I understand and have been provided (brochure available upon request) with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. If I have any further questions in regards to the Privacy Practices I can contact the practice owner. I understand that OPTSH, LLC. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that OPTSH, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

Ok to speak with: _____

I understand that as part of OPTSH, LLC treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax. I fully understand and accept the terms of this consent.

_____ _____

Signature **Date**

I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as indicated:

Date: _____ *Initials:* _____ *Reason:* _____

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Patient Information

Please complete all of the following information:

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

(_____)_____(_____)_____(_____)_____
Home Phone Work Phone Cell Phone

_____
Date of Birth Age Sex E-mail Address

_____
Emergency Contact Phone #

_____
Occupation

_____
Primary Care Physician (Name) Phone #

Diagnosis: _____ Date of Injury: _____

Circle Yes or No:

1. Is the condition for which treatment is being sought
   a. related to an injury on the job? Yes No
   b. related to a motor vehicle accident? Yes No
   c. involved or will it be involved in litigation? Yes No

I authorize OPTSH to release and request information to/from all medical providers.

_____ _____
Signature **Date**

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Past Medical History Form

Name: _____ Date: _____

Are you presently working? ○ Yes ○ No

How many days per week do you exercise? _____

Describe the exercise: _____

Do you have any of the following?

Pacemaker	Yes ○ No ○	Unusual Headache	Yes ○ No ○
Chest Pain / Angina	Yes ○ No ○	Osteoporosis	Yes ○ No ○
Heart Disease / Attack	Yes ○ No ○	Hernia	Yes ○ No ○
High Blood Pressure	Yes ○ No ○	Seizures	Yes ○ No ○
Cancer / Tumor	Yes ○ No ○	Metal Implants	Yes ○ No ○
Kidney Problems	Yes ○ No ○	Dizziness / Fainting	Yes ○ No ○
Stroke	Yes ○ No ○	Fracture	Yes ○ No ○
Bowel / Bladder Problems	Yes ○ No ○	History of Surgery	Yes ○ No ○
Active Pregnancy	Yes ○ No ○	Skin Problems	Yes ○ No ○
Asthma / Breathing Problems	Yes ○ No ○	Nausea / Vomiting	Yes ○ No ○
Depression	Yes ○ No ○	Loss of Balance	Yes ○ No ○
Hypoglycemia / Diabetes	Yes ○ No ○	Difficulty Walking	Yes ○ No ○
Osteoarthritis	Yes ○ No ○	Smoking	Yes ○ No ○
Rheumatoid Arthritis	Yes ○ No ○	History of COVID-19	Yes ○ No ○
Sensitivity to Heat / Cold	Yes ○ No ○	Other _____	

If you answered **Yes** to any of the items above, please briefly explain and give the date if indicated. Include any other pertinent information regarding your past medical history.

_____

_____

Do you have any allergies to medication(s) or latex? ○ Yes ○ No

If yes, please list your allergies: _____

Please list any medications you are taking below:

Medication	Dose	Frequency

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History of Present Illness Form

Name: _____ Date: _____

Check which one applies to your current condition:

☐ Motor vehicle accident ☐ Work-related injury ☐ Injury related to falling

☐ Recurrence of previous injury ☐ Injury related to lifting ☐ Cause unknown

☐ Athletic / recreational injury ☐ Other: _____

Have you ever had these symptoms before? ○ Yes ○ No Have you had related surgery? ○ Yes ○ No

Within the past year, have you had any of the following tests? *(Please circle all that apply)*

☐ Angiogram ☐ EEG (electroencephalogram) ☐ Pulmonary function test

☐ Arthroscopy ☐ EKG (electrocardiogram) ☐ Spinal tap

☐ Biopsy ☐ EMG (electromyogram) ☐ Stress test

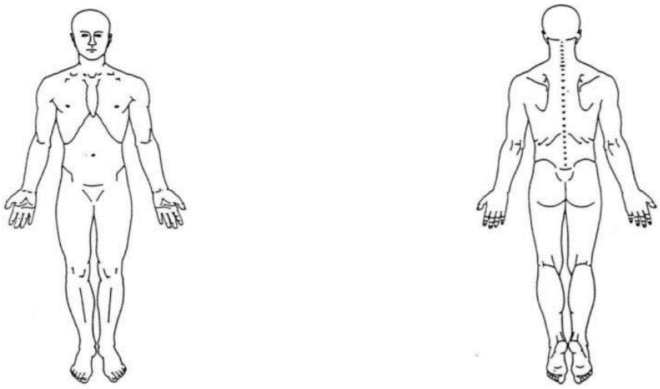
☐ Ultrasound ☐ Bone scan ☐ MRI

☐ X-ray ☐ CT Scan ☐ Myelogram

☐ Venous doppler test

*** We may request from your physician any reports indicated above and other information that would be helpful in the course of your treatment ****

Please draw on the body where you feel your pain or problems:



Please indicate what kind of symptoms you are having, circle all that apply:

☐ Tingling ☐ Numbness ☐ Sharp ☐ Dull ☐ Ache ☐ Tight ☐ Weak

Have you ever taken steroid medication such as prednisone or a cortisone injection? ○ Yes ○ No

Have you ever been placed in a cast, splint, ace wrap, or sling for this injury? ○ Yes ○ No

Are you currently being treated or were you recently treated by any other physical therapist, massage therapist, podiatrist, or chiropractor? ○ Yes ○ No