Informed Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended diagnostic, physical therapy or rehabilitation treatment/procedure to be used so that you may make the decision whether or not to undergo the treatment/procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment/procedure.

I (we) voluntarily request Rural Rehab Providers, LLC d/b/a Lott Physical Therapy, its physical therapists, and such associates, technical assistants and other health care providers as they may deem necessary, do an evaluation, or give advice or with proper referrals to treat my condition which has been explained to me. I (we) understand that the following physical therapy or rehabilitation evaluation, advice or treatment / procedures are planned for me and I (we) voluntarily consent and authorize these procedures. I (we) understand that my physical therapist may discover other or different conditions which require additional or different procedures than those planned and may require consent from my physician before such additional or different procedures are utilized. I (we) authorize my physical therapist, and such associates, technical assistants and other health care providers with consent from my physician to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the diagnostic, physical therapy, or rehabilitation treatment / procedures planned for me. I (we) realize that common to diagnostic, physical therapy, or rehabilitation treatment/ procedures is the potential risk for such procedures and treatment to cause side effects, pain, or other problems.

I certify that the information I have provided is complete and true to the best of my knowledge.

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, medical necessity, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

I have received a copy of the Notice of Privacy Practices for Lott Physical Therapy a d.b.a. of Rural Rehab Providers, LLC. Rural Rehab Providers, LLC reserves the right to modify the privacy practices outlined in the notice.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

COMPLETE IF OVER THE AGE OF 18 YEARS OF AGE:

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I____________________________________**(CLIENT)**, consent to an evaluation, advice or rehabilitation treatment as prescribed by my provider and agree to pay for all services received.

____ __________________

Signature Date

COMPLETE IF THE CLIENT IS A MINOR OR WHEN THE ADULT CLIENT IS NOT COMPETENT:

In the treatment of _______________________________________**(MINOR/ADULT CIENT)**, I ___________________________________, client representative of said minor/adult, consent to an evaluation, advice or rehabilitation treatment as prescribed by minor's/adult's provider . My relationship to the client is (i.e parent, son, daughter, etc) __________________________________.

____ __________________

Signature of Parent/Legal Guardian Date

COMPLETE IF THE CLIENT IS NOT THE FINANCIALLY RESPONSIBLE PARTY:

I agree to pay for all services received.

Printed Name of **Financially Responsible Party** **Phone** **SSN**

Responsible Party's Signature

ALL CLIENTS: MISSED APPOINTMENTS: We work very hard to respect your time by starting your therapy at your scheduled time each visit. We ask that you return that respect by keeping appointments and coming on time to the appointments we've reserved for you.

If you must cancel or reschedule an appointment, please give us AT LEAST 24 BUSINESS HOURS' NOTICE If you give us more than 24 hours' notice we may be able to rebook the appoint**ment that was originally reserved for you. If you do not show up for an appointment or cancel at the last minute, not only do we still compensate the therapist for her/his time, another patient may have gladly taken the appointment but cannot without sufficient notice.**

If you 'No Show' for an appointment and we do not hear from you by the end of that day you will be **removed from any future scheduled appointments. For those that have difficulty making appointments, we are happy to offer same day appointments as available. _____________ Initials**

Client History

Date:___/___/___

Name on insurance card: ____________________________ Preferred name: ___________________

HOME HEALTH:

Medicare and some payors do not reimburse for outpatient Physical Therapy if home care services or assistance is being provided in the home? Have you received any healthcare services or help in the home in the last three months? ☐ Yes If **YES**, Please let receptionist know ☐ No

1. Why are you seeking physical therapy services? ____
   When did the pain or problem begin? ____________________________
2. Have you ever been injured or suffered previous pains/problems in the area(s) before this injury? ☐ No ☐ If **YES**, when? _________________________________
3. Did you recover from this injury? ☐ Yes ☐ No
4. Have you had a recent X-ray, CT, or MRI of injured area? ☐ Yes *(please circle test done)* ☐ No
   When _____________________________ Where ___________________________________
5. Have you had other treatment for this problem recently (chiropractic, massage, personal training, athletic training, injections, etc.) ? ☐ If **YES** *(please circle)* ☐ No
6. Have you ever had Physical Therapy? ☐ No ☐ Yes. If **YES**, When? _______For this condition? ☐ No ☐ Yes If **YES**, When? _______________
7. **Female client:** Are you pregnant? ☐ Yes ☐ No ☐ Unsure
8. Please list below any medication/supplement/vitamins taken on a regular basis.

_____________________ ___________________ ___________________ ____________________

_____________________ ___________________ ___________________ ____________________

_____________________ ___________________ ___________________ ____________________

9. Please list prior surgeries and dates:

Surgery:	Date:

10. Do you have or have you had any of the following?

- ☐ Asthma
- ☐ Breathless at rest or after mild exertion
- ☐ Inability to control bowels or urine (incontinent)
- ☐ Increased urination (frequency)
- ☐ Chest Pain
- ☐ Pacemaker
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Night sweats
- ☐ Pain at night
- ☐ Unexplained weight loss or gain
- ☐ Headaches, dizziness, fainting or falling
- ☐ Vision difficulties
- ☐ Speech difficulties
- ☐ TB
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture Or Suspected Fracture
- ☐ History of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ NONE OF THE ABOVE

Focusing on Correction, Education and Prevention

Welcome to Lott Physical Therapy and Fitness Center!

We realize that you have a choice when selecting your therapy provider. Thank you for choosing Lott Physical Therapy! We will strive to address your personal goals when we develop your program whether those goals involve recovery from an injury, surgical procedure, or general weakness and decline in desired function. We will personalize your care and always provide you feedback on your progress. An individualized treatment plan will be developed during your Initial Evaluation visit to help you achieve your goals and help you reach your highest possible functional level – at home, work and play. This plan will be kept up to date as your symptoms and capabilities change.

Therapy hours are 8a – 5:00p Monday through Friday. An answering machine will take your calls when the office is closed. We ask that you are equally committed to your treatment program. If you are ever unable to attend a scheduled appointment, please notify us at least 24 business hours in advance. This will enable us to offer that appointment to another client. If you are rehabilitating after an injury or surgery, you will also be asked to perform certain exercises at home in order to expedite your recovery. Please know that these exercises are to help you and to give you strategies to manage your symptoms independently. We will always do our best to help you on your road to recovery; however, remember that you will always be in the driver's seat.

Dress comfortably. Loose fitting shirts, loose fitting pants, long shorts, or shorts beneath a skirt are all appropriate. If the therapist is treating a certain area of the body, wear clothing that will make that area easily accessible without having to expose other areas of the body. A dressing area is available if you wish to change at the facility.

Please sign in for each appointment and alert the receptionist any time your address, phone number, payment or insurance information changes. Take a seat; make yourself comfortable and the office staff will come to get you started. If you wait for more than 5 minutes past your scheduled time and haven't heard from our staff, please let us know – we certainly value your time.

Many of our clients wish to continue their home program in our Fitness Center after discharge from Therapy. This will be discussed, if appropriate, during discharge planning. Our therapists develop programs that address special areas of concern as well as general fitness to transition many of our clients to a lifelong healthy lifestyle. **Therapy 'Graduates' receive reduced Fitness Center rates**. In addition, if you require a ride to your therapy appointments, we have a program that allows **drivers to utilize the Fitness Center free of charge while they wait**. The **Kids Korner** is also available for clients needing childcare while in therapy at our Fairfield location: a provider is available M-F 8-10am. Parental or Legal Guardian written consent is required. Please see the receptionist regarding these programs.

We hope your experience with us is your best ever.

Dr David Lott
Physical Therapist, owner

America's Practice of the Year, 2011 *(American Physical Therapy Association)*

Lott Fitness Center open 24 Hours Every Day
Corsicana and Fairfield
903-874-7433   903-389-7433

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. PLEASE REVIEW IT CAREFULLY.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.
Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.
Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.
Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.
Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact: Lisa Lott, Privacy Officer PO Box 1241 Corsicana, TX 75151. Phone 903-874-7433.

Effective Date:

This Notice will take effect on April 14, 2003