# Informed Consent for Physical Therapy Services

*The purpose of study is to treat adhesive capsuilits, by examination, evaluation, diagnosis, prognosis and intervention by use of dynamic scapular recognition exercise, to aid you in achieving maximum treatment potential and to accelerate convalescence and reduce the length of functional recovery. This procedure 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. This study does not guarantee what your reaction will be to rthis specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for.

It is your right to decline any part of the 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 about this treatment 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 authorize the release of my medical information to appropriate third parties.

Patient Name: [redacted] Date_06/01/2022

**AMS Physical Therapy, Inc**
16550 Ventura Blvd, Suite 205
Encino, CA 91436
818.986.9229 T
818.986.9339 F
Alexandra@AMS-PT.com

# Patient Information

Name_____Date of Birth_____

Address_____

City_____State_____Zip_____

Phone_____Mobile_____Work_____

Email_____

Employer/School_____Occupation/Sport_____

How did you hear about AMS Physical Therapy, Inc?_____

Referring MD_____

Seeking treatment for?_____

Pain Onset(injury)_____Date of Surgery_____

Emergency Contact_____Phone_____

Parent or Guardian_____Relationship_____

Privacy Policy: I have read the Health Information Privacy Policy

24 Hour Cancellation Policy: Please provide 24 hour notice in order to reschedule or cancel your appointment. Note that your appointment time is reserved specifically for you; hence, late cancellations without valid reason will be charged the full session amount of $100.

Billing: Co-pays and deductibles will be collected at the time of service. AMS Physical Therapy, Inc will bill your insurance. Please keep in mind that the co-pays collected at the time of service are an estimate of your cost based on benefits quoted by your insurance company and you may be responsible for unpaid or disallowed amounts.

Patient Name_____Signature_____Date_____

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# General Health Questionnaire

Do you experience any of the following symptoms?

| | | |
|---|---|---|
| 1.Fevers/Chills/Sweats | _____Yes | _____No |
| 2.Unexplained weight Loss/Gain | _____Yes | _____No |
| 3.Malaise (feeling generally unwell) | _____Yes | _____No |
| 4.Unusual Fatigue | _____Yes | _____No |
| 5.Nausea/vomiting | _____Yes | _____No |
| 6.Headaches | _____Yes | _____No |
| 7.Dizziness/ Lightheadedness/Loss of consciousness | _____Yes | _____No |
| 8.Blurred vision | _____Yes | _____No |
| 9.Numbness/Tingling | _____Yes | _____No |
| 10.Weakness | _____Yes | _____No |
| 11.Muscle cramping | _____Yes | _____No |
| 12.Chest pain/Palpitations | _____Yes | _____No |
| 13.Swelling in feet or hands | _____Yes | _____No |
| 14.Difficulty breathing/Shortness of breath | _____Yes | _____No |
| 15.Difficulty breathing when lying down | _____Yes | _____No |
| 16.Cough/Change in cough/Blood in phlegm | _____Yes | _____No |
| 17.Wheezing | _____Yes | _____No |
| 18.Difficulty swallowing | _____Yes | _____No |
| 19.Heartburn/Indigestion | _____Yes | _____No |
| 20.Change in appetite | _____Yes | _____No |
| 21.Specific food intolerance | _____Yes | _____No |
| 22.Changes in Bowel pattern (color,texture,frequency) | _____Yes | _____No |
| 23.Difficulty urinating (starting, stopping) | _____Yes | _____No |
| 24.Urine frequency changes | _____Yes | _____No |
| 25.Possibility of pregnancy | _____Yes | _____No |

Other medical conditions or prior surgeries:

_____

_____

Current medications:

_____

_____

Family medical history (birth parents and siblings):

_____

_____

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# Notice of Privacy Policies: HIPAA

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

**Introduction:** AMS Physical Therapy, Inc is committed to treating and using your protected health information in a responsible manner. Federal and state laws require me to maintain the privacy of your protected health information. This Notice of Health Information Practices describes the personal information that I collect, and how and when I use or disclose this information. It also describes your rights as they relate to your protected health information (PHI). This Notice is effective as of April 14, 2003, and applies to all protected health information as defined by federal guidelines and regulations.

**Understanding Your Health Record/Information:** Every time you are treated at AMS Physical Therapy, Inc a typed record of your visit is made. This note contains your symptoms, examination findings, and test results, treatment, and a plan of care for future visits. This information, is referred to as your health or medical record, and it serves as:

* Basis for planning your care and treatment,
* Means of communication among many healthcare professionals that work as a team to deliver care,
* Legal document described the care you received,
* Means by which a third party payer can verify that services billed were actually provided,
* A tool in educating health professionals
* A source of information for public health officials charged with improving the health of this state and nation,
* A source of data for planning and marketing,
* A tool with which I can assess and continually work to improve the care I render and the outcomes I achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand, who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

**Your Health Information Rights:** Although your health record is the physical property of AMS Physical Therapy, Inc, the information belongs to you. You have the right to:

* Obtain a copy of this notice of information practices on request,
* Inspect and receive a copy of your health record as provided for in 45 CFR 164.524,
* Amend your health record as provided in 45 CFR 164.528,
* Obtain an accounting of disclosures of your health information other than for treatment, payment and healthcare operations as provided in 45 CFR 164.528,
* Request communications of your health information by alternative means or at alternative locations,
* Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and

* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**AMS Physical Therapy, Inc is required to:**
* Maintain the privacy of your health information,
* Provide you with this notice as to our legal duties and privacy practices with respect to information that is collected and maintained about you,
* Abide by the terms of this notice,
* Notify you if I am unable to agree to a requested restriction, and
* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

AMS Physical Therapy, Inc reserves the right to change practices and to make the new provisions effective for all protected health information that is maintained. Should information practices change, AMS Physical Therapy, Inc will mail a revised notice to the address you provided on file, or based on agreement, a copy will be emailed to you.

AMS Physical Therapy, Inc will not use or disclose your health information without your authorization, except as described in this notice. Furthermore, AMS Physical Therapy, Inc will discontinue using/disclosing your health information after written revocation of the authorization according to the procedures included in authorization is received.

Uses and Disclosures of Protected Health Information: AMS Physical Therapy, Inc may use or disclose PHI about you for treatment, payment, and health care operations. Following are examples of types of uses and disclosures that the company is permitted to make.

**AMS Physical Therapy, Inc will disclose health information for treatment.**

Example: Information obtained by the physical therapist or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. AMS Physical Therapy, Inc will document in your record, your plan of care, treatment and interventions, observations, symptoms, tests, and measurements and your response to treatment.

AMS Physical Therapy, Inc will provide your physician, case manager or subsequent health care provider with copies of various reports that should assist him or her in your treatment and care.

**AMS Physical Therapy, Inc will use and disclose your health information for payment.**

Example: A bill may be sent to you or a third-party payer. AMS Physical Therapy, Inc may use and disclose your PHI to submit bills to you or a third-party payer for health care services provided to you. AMS Physical Therapy, Inc may disclose your PHI to another health plan, health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for benefits, reviewing services for medical necessity, and performing utilization review of your account.

**AMS Physical Therapy, Inc will use and disclose health information for regular health care operations.**

Example: Health care operations include the business functions conducted by a health care provider. Members of the healthcare staff may use information in your health record to perform transcription duties, as well as assess the care and outcomes in your case and others like it. This information will then be

used in an effort to continually improve the quality and effectiveness of the health care and services that AMS Physical Therapy, Inc provides. These activities may include providing customer services, transcription duties, responding to complaints, conducting review of accounts and other quality assessment and improvement activities.

***Business associates***: There are some services provided through contacts with business associates with whom AMS Physical Therapy, Inc has written agreements containing terms to protect the privacy of your PHI. When these services are contacted, AMS Physical Therapy, Inc may disclose your health information to my business associates so that they can perform the job AMS Physical Therapy, Inc has appointed them to do, which may include billing you or your third-party payer for services rendered. In order to protect your health information AMS Physical Therapy, Inc requires the business associates to appropriately safeguard your information.

***Notification:*** AMS Physical Therapy, Inc may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. As a means of communication AMS Physical Therapy, Inc may: leave a message on your answering machine or on voicemail, mail you a postcard or written notice, email you, your healthcare provider, or case manager.

***Communication with family***: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

***Research:*** AMS Physical Therapy, Inc may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

***Workers Compensation:*** AMS Physical Therapy, Inc may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. This may include communication either in writing, email, or by telephone with a case manager in charge of your case.

***Public Health:*** As required by law, AMS Physical Therapy, Inc may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***Law Enforcement:*** AMS Physical Therapy, Inc may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

***On Your Authorization:*** You may give AMS Physical Therapy, Inc written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give AMS Physical Therapy, Inc the authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give AMS Physical Therapy, Inc a written authorization, this company cannot use or disclose your PHI for any reason except those described in this notice.

**For More Information or to Report a Problem:**

***** If you have any further questions and would like additional information you may contact AMS Physical Therapy, Inc **(**818) 986-9229.

* If you believe your privacy rights have been violated, you can file a complaint with AMS Physical Therapy, Inc, or with the Office for Civil Rights, U.S. Department of Health and Human Resources. There

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will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that AMS Physical Therapy, Inc has engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**I consent to the use or disclosure of my protected health information (PHI) by AMS Physical Therapy, Inc for the purpose of Treatment, Payment, and Health Care Operations. I have read a copy of the Notice of Privacy Practices: HIPAA and understand I have a right to review it prior to signing this document.**

Patient Name: _____

Signature:_____ Date:_____