Vernon Physical Therapy
514 State Route 515
Tel (973) 764-5333 Fax (973)506-1700
vernonphysicaltherapy@gmail.com

CONSENT FOR TREATMENT

1. AUTHORIZATION:

a. I hereby authorize Vernon Physical Therapy professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy & Speech Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

b. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

2. MEDICARE PATIENTS:

a. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

3. GUARANTEE OF ACCOUNT:

a. For and in consideration of services rendered to (Patient Name) by Vernon Physical Therapy. I hereby agree to pay the full bill for all charges which are not paid to Vernon Physical Therapy by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

4. RELEASE OF INFORMATION:

a. I permit Vernon Physical Therapy to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of Vernon Physical Therapy charges.

5. HIPAA – NOTICE OF PRIVACY ACKNOWLEDGMENT:

a. Vernon Physical Therapy has made their Notice of Privacy Practices available to you. Your name, signature, time and date on this cover sheet indicate that you have acknowledged the availability of the Vernon Physical Therapy's Privacy Practices and were given the option to receive a copy for your possession. If you have any questions regarding the information set forth in the Vernon Physical Therapy Notice of Privacy Practices, please do not hesitate to contact

I confirm that I have read and fully understand the above.

Patient Name: Patient Signature: ______________________________

Relative/Guardian (if not patient): (Signature)____________________________________
(Print)______________________________

Relationship (if signed by person other than patient) ____

Rep Name (Witness): Signature____________________________
Print name ______________________________ **Date**_____________________

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Name: ______________________ Date of Birth: ______________________
Address: ______________________
Phone: ______________________
Referring MD: ______________________ Next MD Appointment: ______________________
Current complaint: ______________________
Date of Injury/Onset: ______________________ Work Related/ Auto Accident/ School Injury
If your injury is the result of an accident, in what State did the accident occur? ______________________
If your injury is the result of an accident, is there currently any legal action being pursued? Yes/ No
Occupation: ______________________ Present work status: ______________________
Please list any surgeries and dates below: ______________________
____
What is your goal for therapy? ______________________
Do you have any other aches and pains we should know about? Yes No
If "Yes" please describe: ______________________
Past Medical History - Please check all that are applicable:

High Blood Pressure		Systemic Lupus		Hepatitis	
Stroke		HIV/AIDS		Seizure	
Heart Attack		Rheumatoid Arthritis		Depression	
Diabetes		Kidney Disease		Tuberculosis	
Pacemaker		Currently Pregnant			
Cancer					

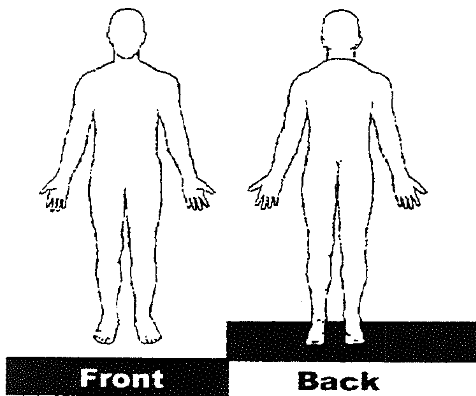
Osteoarthritis/ Osteoporosis Other: ______________________
Cancer - Location(s) and Date(s): ______________________

Please list below any current medications, including dosage and route, you are presently taking (including prescription,over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).
Please see attached copy of medication list provided Not taking any medication.
Name of Medication Dosage Route (by mouth, patch, injection, etc.)

______________________ ______________ ______________________
______________________ ______________ ______________________
______________________ ______________ ______________________
______________________ ______________ ______________________

Please list any X-rays, CT scans, or MRI tests performed and the results: ______________________
____

On the diagram below, mark the location(s) of your pain.



Please indicate the intensity of your pain at its worst:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Please indicate the intensity of your pain at its best:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Please circle the description of your pain (any that apply):
Sharp/ Dull/ Throbbing/ Numbness Shooting Burning Tingling
Constant (>76%) Frequent (51-75%) Occasional (25-50%) Intermittent (<25%)
What increases the pain? ______________________________
What decreases the pain? ______________________________
Have you had physical therapy in the past for this same problem? YES/ NO
Have you had any physical/occupational/speech therapy or chiropractic visits this year? YES/ NO
Number of therapy visits received this year for: PT ________ OT ________ Speech ________
Were you in a hospital or skilled nursing facility within the past 30 days? YES/ NO
If yes, reason for stay ______________________________
Dates of stay: From: ____________________ To: ____________________
Have you recently received any type of home care services? YES/ NO
What was the last date anyone came into your home for services? ____________________
Over the past 12 months, have you fallen 2 or more times? Yes No
Over the past 12 months, have you had 1 or more falls that resulted in injury? Yes No
Do you smoke or use smokeless tobacco products?
No, I do not use tobacco products Yes, I smoke _____ packs per day
Yes, I use smokeless tobacco products _____ times per day
Do you drink alcoholic beverages? No Yes
How many alcoholic drinks per day? _____ How many alcoholic drinks per week? _____

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Patient or Authorized Representative Signature: ______________________________ Date: ____________
Therapist Signature: ______________________________ Date: ____________