PATIENT INFORMATION:

Name:_____ Date of Birth:_____
Name of Parent/Guardian if Minor:_____
Address:_____
Cell Phone: ( )_____Home Phone:( )_____
Email: _____Hobbies/Occupation_____
Emergency Contact:_____ Phone:( )_____
Referring Doctor:_____ Phone:( )_____

FINANCIAL AND APPOINTMENT POLICY:

Susan Casto Physical Therapy (SCPT), provides physical therapy on a "fee for service" basis. By removing SCPT from insurance networks, it does not have to limit the time or quality of treatment provided because of insurance company restrictions or elevate our rates to pay for billing services. I understand that I, the patient/client, am entering into care as a "cash-pay" client. Fees range from $150-225/session, as specifically stated under Appointment FAQ's on this website. By signing this agreement, I understand that SCPT will not be billing my insurance. I understand that my reimbursement benefits for Physical Therapy received at SCPT are out-of-network services and reimbursement is not guaranteed. I agree to pay SCPT for my treatment at time of service, by cash, check, credit card, Venmo or Zelle. 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 agree to pay a $75 fee.
_____(initial)

CONDITIONS FOR TREATMENT:

I understand that the physical therapist cannot make any promises of guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist can share with me opinions and available studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. A good faith estimate will be discussed after evaluation. This is determined by the cost of the eval plus the cost of the recommended number of follow up sessions.

I understand that in order for physical therapy treatment to be most effective, I must come to scheduled appointments 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. I understand that SCPT asks me not to wear perfumes and strong scents to treatments.

Patients are responsible to inform Susan Casto, PT of all medical conditions and their treatment, along with all medications at their initial appointment.

Please inform Susan Casto, PT if you are under the influence of any substance that may affect your safety with treatment or injure someone else (medications, chemotherapy, drugs, alcohol, etc.).

If clarification is needed for any of the above terms or policies, or you have concerns regarding them, please let Susan Casto, PT know in advance of your scheduled appointment.
_____(initial)

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION:

I authorize the mutual exchange of information regarding myself between SCPT and the following persons or professionals:

ACKNOWLEDGEMENT OF RECEIPT OR UNDERSTANDING OF PRIVACY NOTICE:

I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have read the online HIPPA document on this website, and have the right to receive a complete detailed copy of the NOTICE OF PRIVACY PRACTICES upon request. _____(initial)

CONSENT FOR PHYSICAL THERAPY EVAULATION AND TREATMENT USING MANUAL AND VISCERAL THERAPY:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The following information is to inform you of potential risks and benefits.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. You may experience bruising, warmth, redness, aching, increased or decreased gastrointestinal motility, or other mild symptoms in general vicinity of tissues treated. This discomfort is usually temporary. If it does not subside in 24-48 hours, I agree to contact my physical therapist or physician.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You ay experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort, improved energy, mobility and gastrointestinal function. You will have greater knowledge about managing your condition and the resources available to you.

I, the patient, understand in order to best treat my condition that external manual therapy techniques may be performed in the anterior chest region near breast tissue, the anterior pelvic region near genital tissue and structures, and in the posterior and inferior gluteal region near rectum and pelvic bones including sacrum, coccyx, and ischial tuborosities. At any time, if I am uncomfortable with any treatment I will immediately tell my therapist and I understand that I can decline any portion of the evaluation or treatment at any time. I hereby voluntarily consent to physical therapy treatment.

I grant permission to all therapists I may see at SCPT to use all the techniques they know, including soft tissue mobilization, Visceral mobilization, Joint mobilization, Myofascial release techniques, CranioSacral therapy, TMJ techniques, Proprioceptive Neuromuscular Facilitation (PNF) techniques therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me, until am discharged from care.

I have read and fully understand the statements made on this form and agree that they apply to all treatments I receive from Susan Casto Physical Therapy. I know I am responsible for all services received and I agree to pay for any and all services rendered at the time of service, unless previous arrangements have been made. By signing this document, I state that I have read and understood each of the terms and policies above, and that I agree to the conditions stated in this form.

Patient/Client/Guardian signature _____Date:_____

MEDICAL HISTORY AND SELF ASSESSMENT

List Medications you are taking:

_____
_____
_____
_____
_____

Check all the statements that are true:

___Changes in my bladder or bowel function
___Swelling in ankles/feet or hands
___Numbness or tingling in feet/legs or hands/arms
___Unexplained loss or gain of more than 10 pounds the last 6 months
___I have had recent internal bleeding (ulcer, intestinal, etc)
___I have an implant (IUD, pacemaker, stint, other)
___Eating changes my symptoms
___Blurred vision
___I feel dizzy
___I wake with night pain
___I have had a recent infection
___I am pregnant or plan to start
___I am sensitive to manual treatment
___There is a lawsuit, or potential lawsuit regarding my condition

Any other information you would like to add about your current state of health?