3774

LOMA LINDA UNIVERSITY
HEALTH

Neuropathic Therapy Center

ADULT PATIENT TREATMENT PROGRAM AGREEMENT

AGREE THAT:

- I want to achieve the highest level of functional independence as is possible for me. With this goal in mind, I commit to full participation while attending my therapy sessions as well as following through with my Home Exercise Program (HEP) as prescribed by my therapy team.
- I will be on time for my scheduled appointments. I understand that late arrival may result in my appointment being rescheduled or a partial treatment.
- I understand that a pattern of poor attendance on my part may cause changes in my schedule. A therapy session will not be extended because of my tardiness.
- If I need to cancel my therapy appointment for any reason, I will do so 24 hours in advance, when possible by calling 909-558-6799.
- I understand that I may be asked to follow up with my personal physician in order to obtain a prescription for ongoing therapy or if the therapist feels I have signs or symptoms of a condition that requires treatment beyond the practice of a physical therapist.
- My family is an important part of my Neuropathic Therapy team. They will attend therapy sessions as needed, and ask what they need to know about my care.
- If we are contracted with your insurance carrier, I will take it upon myself to learn about my medical insurance policy, the services and equipment that are covered, as well as the authorization requirements and process, by telephoning the member services number on my insurance card. I will also be responsible for tracking dates in accordance with what my insurance has agreed to pay for.
- If I am hospitalized at any time during the course of my treatment program, I will notify the Neuropathic Therapy Center as soon as possible.
- Neuropathic Therapy setting has been determined to be a "Fall Precaution Area". In order to ensure patient safety during the therapy visit all fall prevention interventions, including the constant supervision of the patient while in the NTC area(s), offering frequent toileting and use of a chair with sides for wheelchair bound patients, are to be implemented pre and post procedures as applicable.
- If the patient is under the age of 18 years old, he/she must be accompanied by the parent or legal guardian. If anyone other than the parent or legal guardian accompanies the patient, a notarized letter will be required for the patient to receive service(s).
- In signing, I agree to the above and to treatment provided by this facility.

Patient Name (print):_____ Patient Signature:_____ Date: _____

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ADULT PATIENT TREATMENT PROGRAM
AGREEMENT ACKNOWLEDGMENT

- You are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits. Whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving a dated signature on the physical therapist's plan of care, indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist. We are also informing you of the financial interest of this therapy clinic and all members within providing your health care. Initials:_____

Patient Name (print):_____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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ADULT PATIENT TREATMENT PROGRAM AGREEMENT
PATIENT HISTORY

Please complete as thoroughly as possible, if you need more space, use the back of this form.

How did you hear about us?_____

Diagnosis/Reason for your visit:_____ Date of injury/Onset: _____

Primary physician:_____ PCP phone number:_____

Other physicians currently treating you: _____

How did your problem begin?_____

Have you received therapy in the past for this condition? _____

Did your problem occur in the course of employment? ☐ Yes ☐ No Do you have lifting restrictions?_____ lbs.

Has your physician given you any other restrictions? _____

What is your occupation?_____

Are you currently working? ☐ Yes ☐ No Are you on permanent disability? ☐ Yes ☐ No

MEDICAL HISTORY (Please check all that apply)

☐ High/Low Blood Pressure
☐ History of Smoking
☐ Diabetes
☐ Heart Problems:
_____
☐ Stroke
☐ Cancer
☐ Kidney Problems
☐ Head Injury
☐ Headache/Migraines
☐ Seizures/History of Epilepsy
☐ Vertigo
☐ Pacemaker
☐ Hernia
☐ Arthritis
☐ Osteoporosis (brittle bones)
☐ Rheumatoid Arthritis
☐ Thyroid Disease
☐ Tuberculosis
☐ Skin Disorders
☐ Emphysema
☐ Fractures
☐ Shortness of Breath
☐ Asthma
☐ Viral Infections:
_____
☐ Currently Pregnant
☐ Allergic to Tape or Latex
☐ History of Aneurysm

Other medical conditions: _____

List previous surgeries:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

List recent hospitalizations, reason for hospitalization, where, and when:_____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CONDITIONS THEY ARE FOR:

_____

_____

List any medications you are allergic to:_____ Other allergies:_____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:

☐ Fever/Chills/Sweats
☐ Unexplained Weight Change
☐ Malaise/Fatigue/Loss of Energy
☐ Nausea/Vomiting
☐ Bowel Dysfunction, Incontinence
☐ Numbness_____location
☐ Weakness_____location
☐ Fainting
☐ Dizziness/Lightheadedness
☐ Night Pain
☐ Difficulty Breathing
☐ Difficulty Urinating
☐ Difficulty Swallowing
☐ Urinary Frequency Changes
☐ Sexual Dysfunction

Person completing this form: ☐ Patient/Self Or _____ Relationship:_____

Emergency Contact(s): Name:_____ Relationship:_____

Phone 1:_____ Phone 2:_____ Phone 3:_____