MONTOYA
PHYSICAL THERAPY
AND WELLNESS

# INFORMED CONSENT AND LIABILITY WAIVER FORM

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, ethnicity, creed, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention. Treatment may consist of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential for recovery within their capabilities. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to fully cooperate with the evaluation and treatment program. There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing levels of difficulty that could increase your level of pain or discomfort with a current or previous injury. You will be able to stop treatment if you feel any discomfort or pain. Your therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read the consent form and authorize the release of medical information to appropriate third parties.

I hereby release Montoya Physical Therapy and Wellness, Rick Montoya, PT, DPT; Derek Boss, PT, DPT and Robert Dator, PTA from any responsibility or liability due to my participation in physical therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold those named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in.

Print Name_____

Signature: _____

Date: _____

*If under 18 years of age, please complete and sign below*

Parent or Legal Guardian Name_____

Parent or Legal Guardian Signature _____

# PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Montoya Physical Therapy and Wellness (MPTW) for your physical therapy needs. It is our commitment to provide you with the highest quality physical therapy services. We know you have other options and are honored by your choice. Below, please read and sign this form to acknowledge your understanding of our patient financial policies.

***INSURANCE COVERAGE and CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES***

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements.
- As a courtesy, we attempt to verify that your insurance coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, you are financially responsible for all services not covered by your insurance company.
- At each visit, you will be expected to pay the amount verbally quoted to us by your insurance company, including any outstanding deductibles.
- You will be responsible for a $25.00 service fee if your check is returned by the bank for non-payment.

***CREDIT CARD ON FILE /CANCELLATION AND RESCHEDULE POLICY***

- MPTW requires all patients to provide a current credit card "on file" when making an appointment for a consultation and/or treatment. We understand there may be times when you need to reschedule an appointment due to an emergency, or obligations to work or family. In these cases, we **require a 24-hour** prior notice by phone to cancel or reschedule your appointment. The "on file" credit card will be charged **Fifty Dollars ($50.00**) the day of the missed appointment if the 24-hour prior notification is not received timely. Please note the credit card "on file" will only be charged if there is no 24-hour notice. As respect to other patients and our staff, any patient with more than three (3) no show appointments may be discharged from care.

***INSURANCE COMPANY REQUESTS***

- You are responsible for responding to any request from your insurance company if further information is needed. Not doing so could result in a claim denial and you will be responsible for payment to MPTW.

***INSURANCE PAYMENTS SENT TO YOU***

- If insurance payments are sent to you directly, you are responsible for forwarding them to our office with a copy of the Explanation of Benefits (EOB).

***NON-PAYMENT/COLLECTION ACCOUNTS***

- In the case your account is forwarded to a collection agency, you are responsible to pay reasonable attorney fees if applicable.

***I hereby authorize Montoya Physical Therapy and Wellness to release my medical information to my insurance company for the purpose of payment. I hereby authorize and direct my insurance company to pay Montoya Physical Therapy and Wellness directly. I understand that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due. I authorize Montoya Physical Therapy and Wellness to charge my credit card "on file" for any appointments not attended without a 24-hour notification.***

Patient Name_____ Date_____

Signature: _____

*If patient is under 18 years of age, please complete and sign below*

Parent or Legal Guardian Name_____ Date _____

Parent or Legal Guardian Signature _____ Date _____

Rev. 9/2023

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Dr. Rick C. Montoya, PT, DPT
Dr. Derek C. Boss, PT, DPT
Kelly A. Montoya, DPT
Marci Dahm, PT, MPT
Cesar Z. Ibarra, PTA

# PATIENT REGISTRATION

Last Name:_____ First:_____MI:_____

Date of Birth:_____/_____/_____Age:_____ Sex: M F Marital Status: _____

Home Address:_____

City: _____ State:_____ Zip: _____

Employer:_____ Occupation:_____

Work Address:_____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone: _____Work Phone: _____

***Please circle the phone number above that is the best to contact you

E-mail Address:_____

Emergency Contact:_____Phone: _____

Address: _____

City:_____State:_____Zip: _____

Relationship to you: _____

Referred by: _____

Primary Physician:_____Phone: _____

Would you like to receive confirmation of your appointments? Y N

How did you find out about us? _____

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# PATIENT HEALTH QUESTIONNAIRE AND HISTORY

1. Have you ever had? (If yes, please explain)
   - High blood pressure Y/ N_____
   - Heart or circulation Disorders Y/ N_____
   - Seizures Y/ N_____
   - Dizzy spells Y/ N_____
   - Diabetes Y/ N_____
   - Cancer Y/ N_____
   - Arthritis Y/ N_____
   - Immune deficiency disease Y/N _____
   - Leakage of bladder or bowel Y/ N_____
   - Frequent urination Y/ N_____
   - Painful intercourse Y/ N_____
   - Depression Y/ N_____
   - Headaches Y/ N_____
   - Other Y/ N_____
2. Please list any surgeries you have had along with procedure and dates:

   _____
3. Do you have any METAL anywhere in your body (pins/ plates/ pacemaker) other than teeth?

   Y/ N Describe:_____
4. For women only: Are you now pregnant? Y/ N If yes, how many weeks pregnant?_____

   Are you post-menopausal? Y/ N If yes, date of last period?_____
5. Do you have any abnormal trouble with vision? Y/ N Hearing? Y/ N
6. List all allergies you may have:_____
7. Have you ever taken steroids or anti coagulants for an extended period of time? Y/ N
8. Have you had any unusual weight gain or loss? Y/ N
9. List all medications you are now taking:_____

   _____

# Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

*ACN Group, Inc. Use Only rev 7/18/05*

***Patient Name*** _____ ***Date*** _____

***1. Describe your symptoms*** _____

_____

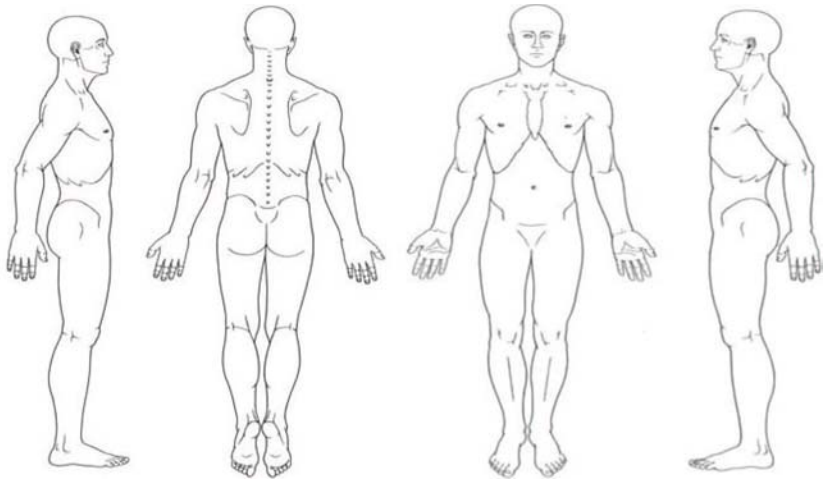
*a. When did your symptoms start?* _____

*b. How did your symptoms begin?* _____

***2. How often do you experience your symptoms?***

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

***Indicate where you have pain or other symptoms***



***3. What describes the nature of your symptoms?***

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

***4. How are your symptoms changing?***

① Getting Better
② Not Changing
③ Getting Worse

***5. During the past 4 weeks:***

*a. Indicate the average intensity of your symptoms*

*None* ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

*b. How much has pain interfered with your normal work (including both work outside the home, and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

***6. During the past 4 weeks how much of the time has your condition interfered with your social activities?***
*(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

***7. In general would you say your overall health right now is...***

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

***8. Who have you seen for your symptoms?***

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*a. What treatment did you receive and when?* _____

*b. What tests have you had for your symptoms and when were they performed?*

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

***9. Have you had similar symptoms in the past?*** ① Yes ② No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

***10. What is your occupation?***

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

*a. If you are not retired, a homemaker, or a student, what is your current work status?*

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

***Patient Signature*** _____ ***Date*** _____

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# AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

**Authorization for Use/Disclosure of Information:** I voluntarily consent to authorize Montoya Physical Therapy and Wellness to use or disclose my health information during the term of this Authorization to my primary or referring physician.

**Recipient:** I authorize my health care information to be released to the following physicians:

- ***Primary*** Physician: _____
- Primary Physician Address: _____
- ***Referring*** Physician: _____
- Referring Physician Address: _____

**Purpose:** I authorize the release of my health information to my doctor for monitoring my progress in physical therapy.

**Information to be disclosed:** I authorize the release of all of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

**Term:** I understand that this Authorization will remain in effect from the date of this Authorization until my discharge from physical therapy.

**Redisclosure:** I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Montoya Physical Therapy and Wellness. If I change my mind, I understand that I can revoke this authorization by providing a written notice to staff at Montoya Physical Therapy and Wellness. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name Relationship Date

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

**Montoya Physical Therapy and Wellness**
**Notice of Privacy Practices for Protected Health Information**
**Effective Date: 7-25-11**

**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!**

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

**Examples of Uses of Your Health Information for Treatment Purposes are:**

- We disclose medical information to our employees and others who are involved in providing the care you need.
- During the course of your treatment, the therapist determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.
- We may disclose medical information if you request a reminder for appointments.

**Example of Use of Your Health Information for Payment Purposes:**

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

**Example of Use of Your Information for Health Care Operations:**

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services. We may also share your medical information with our business associates, such as our billing service, that perform administrative services for us.

**Your Health Information Rights**

**The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:**

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that: If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Jennifer Ballentine Evans or Matthew Evans, in person or in writing, during regular, business hours. [S]he will inform you of the steps that need to be taken to exercise your rights.

**Our Responsibilities**

**The office is required to:**

- Maintain the privacy of your health information as required by law; Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this Notice; Notify you if we cannot accommodate a requested restriction or request; Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.