

Consent for Services by a Physical Therapist

Physical Therapist's Scope of Practice

In the state of California, physical therapists can see clients for an unlimited number of visits and amount of time without a medical referral for *wellness and fitness purposes*. Physical therapists may identify areas of pain, movement or functional impairments, muscular weakness, range of motion deficits, or structural dysfunction, but physical therapists may not give a specific medical diagnosis.

As of January 1, 2014, persons may directly access physical therapists for treatment without first seeing a physician per the section below on Direct Physical Therapy Treatment Services.

Direct Physical Therapy Treatment Services

*Please Read and Sign this section **ONLY** if you are seeking treatment by a physical therapist for a specific injury or medical condition **and have not yet seen** your physician. **You may skip this section** if you are seeing a physical therapist for wellness/fitness services **or** if you already have a prescription from your MD, DO, DPM, or DC.*

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you 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, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, 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.

Patient Name (Please Print)

Signature

Date

Informed Consent for Physical Therapy Treatment

1. **Insurance:** We are an out-of-network provider. I understand that ProBalance, Inc.'s physical therapy services are billed to the patient and that full payment is due at the time of service. It is highly recommended that you verify your Physical Therapy Benefits directly with your health plan, including but not limited to deductibles, co-pays, number of visits allowed, prescription/pre-authorization required. You agree to be held financially responsible for the treatment provided to you.

When a person initiates physical therapy treatment services directly, pursuant to the direct access section, it is important to note that some insurance companies may still require a specific diagnosis code from the appropriate diagnostician for reimbursement.

2. **Informed consent for treatment:** The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. ProBalance, Inc. provides a wide range of services. I understand that I will receive information from ProBalance, Inc. at the initial visit concerning the treatment and options available for my condition.
3. **Potential benefits.** Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. Nevertheless, benefits are not guaranteed to be permanent. I understand that ProBalance does not provide a guarantee and that potential benefits may be temporary.
4. **Potential Risks.** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. I understand that it is my obligation to keep ProBalance, Inc. informed of my present condition and any unanticipated pain or discomfort as a result of physical therapy.
5. **No warranty:** My physical therapist at ProBalance, Inc. will share with me his or her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. I understand that my physical therapist at ProBalance, Inc. cannot and will not make any promises or guarantees regarding a cure for or improvement in my condition.
6. **Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my primary care physician or specialist.
7. **Waiving Copay/Co-Insurance:** Due to Federal False Claims Act, the Federal Anti-Kickback Statute, and State and Federal Insurance Fraud laws, it is unlawful to waive a copay/coinsurance payment. In other words, ProBalance, Inc. may not submit to an insurance company charges for physical therapy services as a courtesy to the patient and then waive the remaining copays/co-insurance if full payment is not received. Exceptional cases do apply for those who meet the criteria for receiving financial assistance under federal standards. Refer to the Department of Health & Human Services for details.

THE UNDERSIGNED ACKNOWLEDGES HAVING READ AND UNDERSTOOD THE ABOVE INFORMATION. THE UNDERSIGNED HEREBY CONSENTS TO PHYSICAL THERAPY EVALUATION AND TREATMENT BY A PHYSICAL THERAPIST AT PROBALANCE, INC. I, THE UNDERSIGNED, ALSO ACKNOWLEDGE THAT I WILL ABIDE BY THE CONDITIONS AND POLICIES NOTED ON THIS CONSENT FORM.

Name (Please Print)	Signature	Date
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 If signing on behalf of a patient as a Guardian, Agent, or other Legal Representative:

Name (Please Print)	Signature	Date
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 Relationship