Welcome to Sports + Orthopedic Leaders (SŌL) Physical Therapy + Performance Training

Move Beyond Pain + Move For Life

Thank you for choosing SŌL as your provider for rehabilitation, wellness, and fitness services.
Our entire staff is committed to serving you and making your rehabilitation experience enjoyable and successful.
Please take a few minutes to read this information so that you can become familiar with our practice.

Mission Statement

SŌL Physical Therapy + Performance Training is committed to excellence in the provision of physical therapy, wellness, and fitness services that enable our clients to move beyond pain and move for life. Through professionalism, caring, realistic and responsive goal-setting, individualization of programming, and focus on results, our physical therapy and fitness services models are designed to be both cost effective and functionally effective.

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

This page must be read and signed before we can see you for physical therapy services.

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. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Please read below for an explanation of potential risks, potential benefits, and alternatives to treatment:

Potential 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.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist at SŌLPT, Inc. cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print Name	**Patient Signature** *(If patient is a minor, this and all following signatures must be that of a legal guardian.)*	**Date**

Patient Physical Therapy Goals and Medical History

Type of Injury/Condition _____ Onset/Injury Date _____

(If Applicable) Type of Surgery _____ Surgery Date _____

What are your goals for physical therapy? _____

Please describe your physical limitations as a result of this injury or condition: _____

Please describe any activities or movements that aggravate your symptoms: _____

Please describe any previous injury or injuries that could affect care: _____

Have you had any of the following diagnostic tests in relationship to this injury? *(Circle all that apply)*

X-Ray CT Scan MRI Doppler Ultrasound

Which of the following describes your pain? *(Circle all that apply)*

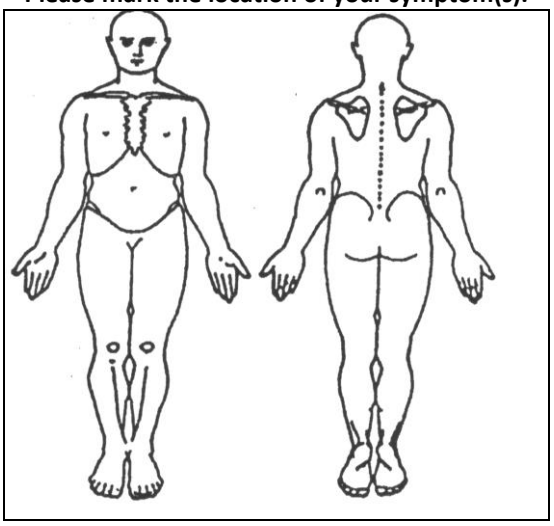
Sharp Aching Burning Tingling Numbness

Other: _____

Please Rate Your Pain (0 = None, 1=Minimal, 10 = Severe)

At Present	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Please mark the location of your symptom(s).



Are you currently taking medications? Yes No

Please List All Medications: _____

Have you recently noticed any of the following? *(Check all that apply)*

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/Sweats
- ❒ Insomnia
- ❒ Nausea/Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

Do you have now or have you ever had any of the following?

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary Problems/ Infections

Please explain and give approximate dates for any conditions marked above:

_____

_____

_____

Patient Demographics and Insurance Information

Demographic Information

Full Name *(As it appears on Insurance Card)* | Preferred Name/Nickname | Primary Phone #

Date of Birth | Age | Gender | SSN *(Worker's Comp/Medicare ONLY)* | Secondary Phone #

Street Address *(Best for sending bills/account Info)* | City | State | Zip

Email Address (*We use this to send you your Home Exercise Program and important clinic announcements)*

Emergency Contact Name | Emergency Contact Phone # | Relationship

How did you find out about SOL? Yelp Physician Facebook Twitter Word of Mouth SOL Website
(Please Circle One)

Other (Please Specify): _____

Physician Information

Name of Primary Care Physician (If Applicable) | Primary Care Physician Phone #

Internal Use Only

To be filled out by SOLPT staff only.

Financial Class
- ❒ In Network Insurance
- ❒ Out of Network Insurance
- ❒ Self-Pay
- ❒ Wellness

In-Network Type of Insurance
- ❒ PPO
- ❒ Medicare
- ❒ Auto
- ❒ Workers' Comp

PT and Dx

Assigned Physical Therapist

Diagnosis (When Applicable)

HIPPA Regulations and Privacy Practices

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices. This is listed on our Web site: www.solpt.com.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Release of Medical Information and Assignment of Benefits; Acknowledgement of Understanding

By signing below, I am verifying that the following are true:

- I authorize the release of medical information necessary for filing health insurance claims for me by SŌLPT.
- I authorize my insurance carrier(s) to make payment directly to SŌL Physical Therapy.
- I have read, understand, and agree to use of my information as listed above.

Print Name | **Patient or Guardian Signature** | **Date**

Marketing Consent

SŌL takes pride in providing you with helpful information and educational material during the course of your treatment and after you care. We also take pride in allowing you to decide exactly how much information you receive from us. **By checking the boxes below, please indicate your marketing preference**

I would like to receive the following from SOL: (Check all that apply)	**I would prefer to not receive any educational information from SOL.**
❒ SOL's Email Newsletter (Once Per Month) ❒ SOL's Print Newsletter (Once Per Month) ❒ Notices of Specials and Discounts Related to Services	❒ Please add me to SOL's Opt-Out List.

By signing below, I acknowledge that I understand this consent form is related to marketing communications only. SOL reserves the right to use my contact information to send communications regarding patient care, billing, or treatment-related needs. If I sign this without checking any boxes, it is an indication of no preference.

Print Name | **Patient or Guardian Signature** | **Date**

SŌLPT Essential Information and Office Policies

Summary: *The following pages will orient you to insurance information, payment information, and office policies that will help make your treatment experience at SOL as seamless as possible.*

Your signature will be required on Page 8 to establish that you've read and understand everything explained.

A Note on Physical Therapy

Many people seek physical therapy for declining function, postsurgical issues, acute injury/trauma, chronic disease or condition, deconditioning, complex pain, stress overload, repetitive overuse injuries and more. Physical therapy treatment involves mobility planning/skilled interventions, and is based on movement impairment models. Goals are established at the time of examination, will relate to improving one's physical functioning, and will be modified based on limitations, real-life considerations, and individual progress.

Office Information

Office	SOL Main Office	SOL Performance	SOL Walnut Creek
Office Nickname	"Upper Piedmont"	"Lower Piedmont"	N/A
Address	4341 Piedmont Avenue 2nd Floor Oakland CA, 94611	3900 Piedmont Avenue Oakland, CA 94611	800 South Broadway Suite 309 Walnut Creek, CA 94596
Cross Streets	Pleasant Valley, Glen Eden	Montell	Newell, Mt. Diablo
Phone Number	**510.547.1630**	**510. 594.1594**	**925.977.9300**
Phone Hours	8:00am – 12:00pm 1:00pm – 5:00pm	8:00am – 12:00pm 1:00pm – 5:00pm	***MWF*** 8:00am - 5:00pm **Tu** 11:00pm – 6:00pm **Th** 2:00pm – 7:00pm
Fax Number	510.923.1944	510.923.1944	925.952.9568

Appointments

Office hours are by appointment only. We respect your personal schedules and make every effort to accommodate your special scheduling needs. To change appointments, we require 24 hours' notice. (Please see cancellation policy.)

Attire – What to wear to physical therapy.

Please wear loose, comfortable clothing to your visits. Clothing that can be easily moved aside to access the affected area or injury, and clothing that you can move in is best. (Think loose workout clothes.)

Amenities

Lockers

While SOL does not take any responsibility for the safekeeping of your personal belongings, we do offer lockers and locks/keys at both the 4341 and 3900 piedmont avenue locations. If you choose to place your belongings in lockers, you are required to obtain a lock/key from the front desk staff (please do not just place items in the lockers without obtaining a lock or key).

Parking

There are parking spaces available for your use at all three of our East Bay locations.

- **4341 Piedmont:** The first 6 spaces on your right as you enter the parking lot are labeled for SOL and available for your use.
    - **PLEASE NOTE:** If you park in any spots not labeled "SOL" in the parking lot, the other business will mark your car for ticketing or towing. SOL is not responsible for any associated costs if this occurs.
- **3900 Piedmont:** There are 6 spaces behind the building for your use.
- **Walnut Creek:** You are welcome to park in any of the spaces to your left as you enter the parking lot.

SŌLPT Essential Information and Office Policies

Financial Payment Arrangements

It is our policy in this office to maintain your account on a current basis. **Charges for services are due at the time the service is provided** Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month. An interest charge of **1%** per month may be applied to all past due balances.

Voluntary Termination of Care

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

Acknowledgement of Responsibility and Understanding

Please Initial All Sections to Indicate Understanding of Responsibilities

Physical Therapy/Amenities

It is the patients' responsibility to:

- Wear loose, comfortable clothing they can move in to sessions.
- Obtain locks and keys, should they wish to use the lockers.
- Park ONLY in spaces designated for SOL clients at the 4341 Piedmont Avenue Location

_____ Initials

Financial Responsibility

- It is the patient's responsibility to pay for any balances due in a timely manner for services rendered.

_____ Initials

SOL's Responsibilities

It is SŌL Physical Therapy's responsibility:

- To provide quality wellness services..
- To answer all patient question about payment to the best of our ability.

_____ Initials

By signing below, I acknowledge that I have read, understand, and agree to all policies and responsibilities set forth in the pages entitled "SOLPT Essential Information and Office Policies."

Print Name	**Patient or Guardian Signature**	**Date**

Direct Access Treatment Services Disclosure

Under California law, persons seeking insurance coverage for physical therapy may access physical therapy services provided by a licensed physical therapist *without* a physician's referral for 12 visits or 45 days (whichever occurs first).

If, at any point, you wish to seek insurance coverage for services after the initial Direct Access period you must:

- Obtain a prescription/referral from a California board certified physician, surgeon, orthopedist, or podiatrist acting within the scope of their practice.
- The prescription/referral must be signed by the practitioner and dated before your first visit following the expiration of the initial treatment period.
- Upon receipt of the referral, and with your permission, your physical therapist will inform your referring practitioner that they are managing your rehabilitation.

By signing below, you acknowledge that you have read the above information.

Print Name	**Patient or Guardian Signature**	**Date**

Commitment to Physical Therapy
Late, No-Show, Reschedule, and Cancellation Policies

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we feel it is our duty to do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Commit to Your Appointments

- With the exception of serious emergencies your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible.
- **Please Note:** In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care.

Late Policies

- If you are less than 15 minutes late and have contacted SOL to warn us that you'll be late, you may complete the remaining time scheduled for your session, **knowing that you will not receive a full session.**
- If you are more than 15 minutes late and have not contacted SOL, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $65 fee.

No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $65 no-show fee.
- **Reminder Calls:** While we offer automated reminder calls as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. **If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the $65 no-show fee.**

Cancellation Policies

- If you need to reschedule a session, you are more than welcome to do so, as long as you **provide more than 24 hours' notice before your scheduled appointment.**
- **Late Cancel:** If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $65 cancellation fee.

Reschedule Policies

- If you need to cancel a session, you are more than welcome to do so, as long as you **provide more than 24 hours' notice before your scheduled appointment.**
- **Late Reschedule:** If you try to reschedule an appointment within 24 hours of your appointment this is considered a Late Reschedule and we reserve the right to charge you a $65 cancellation fee unless:
    - You reschedule your appointment to later the same day (if there is time available). **OR**
    - We are able to fill your vacated slot with another client.

Paying Cancellation/No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the $65 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to discontinue services.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Print Name	Patient or Guardian Signature	Date