BodyGears
Physical Therapy
Enhancing Human Mechanics

www.BodyGears.com 877-709-1090

Consent for Treatment

I, the undersigned, do hereby agree and give my consent for Body Gears Physical Therapy to furnish medical care and treatment to myself or _____ , considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature _____ Date _____

Cost for your appointment:

Illinois:

20 Minutes = $75	40 Minutes = $150	60 Minutes = $200	House Call = $350

California:

30 Minutes = $100	45 Minutes = $150	60 Minutes = $200	House Call = $350

Missouri:

20 Minutes= $60	40 Minutes = $120	60 Minutes = $180	House Call = $350

Payment is due at the time services are rendered in the form of cash, check, or credit card.
Please note, any checks returned as non-sufficient funds will incur a $25.00 fee.

Patient/Guardian Signature _____ Date _____

Cancellation Policy

Together, you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you give us 24-hour notice (business days only) prior to your scheduled appointment time by calling (877) 709-1090. For house call visits cancelled within 24 hours, a 100% cancel fee will apply as we cannot reschedule new patients with such short notice. For self-pay patients being seen in one of our clinics, a $25 cancellation fee will apply.

I acknowledge that I have read and understand this cancellation policy.

Patient/Guardian Signature _____ Date _____


PRINT

FILL OUT

FAX to **866-221-3400**
& bring to your appointment.

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PATIENT MEDICAL HISTORY

Name: _____

Diagnosis/What body part(s) you are being referred for:

_____

Dates Symptoms Began: _____

Please Check: ☐ Work Injury ☐ Motor Vehicle Accident
☐ Other _____

Did this injury require surgery? ☐ Yes ☐ No

Kind of surgery and Date: _____

What medications are you taking for your current injury (if any)?

_____

_____

Please list all Medications:

_____

_____

Mark on the scale below your pre-injury level of function:
☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Mark on the scale below your present level of function:
☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Please describe the location of your pain:

_____

Please indicate which of these words, if any, describe your pain. Check all that apply.
☐ Aching ☐ Numb ☐ Shooting ☐ Tingling
☐ Burning ☐ Sharp ☐ Throbbing

Rate your pain intensity on a scale of 0-10. (0 being no pain)
Current pain _____ /10
At best _____ /10
At worst _____ /10

Which activities increase your symptoms? Check all that apply.
☐ Bending ☐ Reaching ☐ Squatting ☐ Walking
☐ Driving ☐ Reclining ☐ Stairs
☐ Kneeling ☐ Rising ☐ Standing
☐ Lifting ☐ Sitting ☐ Twisting
☐ Other _____

What eases your symptoms?
☐ Moist Heat ☐ Ice Application ☐ Medication
☐ Rest ☐ Change in position
☐ Other _____

Normal Physical Work Activities:

_____

_____

Is your condition overall:
☐ Improving ☐ Getting Worse ☐ Staying the same

Have you had any treatment of this current problem in the past?
☐ Yes ☐ No

Have you received any of the following tests for this problem?
☐ X-rays ☐ CT Scan ☐ Bone Scan
☐ EMG ☐ Nerve Conduction Study ☐ MRI
☐ Other _____

Medical History Information: If you have/had any of the following conditions, please check and give approximate dates or indicate current. If it does not apply, please write N/A.

☐ Arthritis _____
☐ Asthma _____
☐ Blood Pressure Problems _____
☐ Broken Bones _____
☐ Convulsions _____
☐ Diabetes _____
☐ Disabling Headaches _____
☐ Disc Trouble _____
☐ Fainting Spells _____
☐ Heart Problems _____
☐ Osteoporosis _____
☐ Pacemaker Implantation _____
☐ Paralysis or Muscle Weakness _____
☐ Pregnancy _____
☐ Spine Issues _____
☐ Tumor or Cancer _____
☐ Other _____

Please list ALL previous surgeries and the year performed regardless of body part:

_____

_____

_____


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Body Gears Physical Therapy Client Waiver

I, _____ , acknowledge the service I am about to receive through Body Gears Physical Therapy is for at least one of the following services which are non-reimbursable through insurance: maintenance, preventative, and/or performance based enhancements.

I understand these services are not reimbursable through insurance, and I will not file an insurance claim for these non-reimbursable services.

I understand I need to procure a diagnosis from a physician (or physician equivalent) for these non-reimbursable services.

Print Name _____

Signature _____

Date _____


PRINT


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