CALIFORNIA HAND & PHYSICAL THERAPY, INC

Patient Information Sheet

Name _____ [M / F] DOB _____ Age _____

Address _____ City/State _____ Zip _____

Phone _____ Cell _____ Work _____

Social Security No _____ Drivers License No _____ Email _____

Nature of Injury *(please circle):* At home? At school? Recreationally? Work injury? Car accident?

Referring MD _____ Injured Body Part _____

Date of Injury _____ Is this a Workers' Comp Injury? *Yes / No* Are you able to work? *Yes / No*

Have you had surgery on the injured area? If so, type and date of surgery _____

Employment Status: Full Time Part Time Not Employed Student Retired

Occupation _____ Employer _____

Work Address _____ City/State _____ Zip _____

Personal Status: Married Single Divorced Minor/Child Widowed Legally-Separated

Spouse / Emergency Contact _____ Phone _____

Primary Insurance Co: _____ [PPO / HMO] ID No: _____

Subscriber _____ Sub DOB _____ SSN _____

Secondary Insurance Co _____ ID No _____

Subscriber _____ Sub DOB _____ SSN _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from California Hand and Physical Therapy, and consent to medical treatment, whether covered by insurance or not.

Patient Signature _____ Date _____

CALIFORNIA HAND & PHYSICAL THERAPY, INC

Assignment of Benefits

FINANCIAL POLICY STATEMENT

I hereby assign all medical benefits to which I am entitled, including Medicare, Medi-Cal, Private Insurance and third party payors to California Hand and Physical Therapy, in the event they file insurance on my behalf. I hereby authorize California Hand and Physical Therapy to release all information necessary to secure the payment of said benefits. A copy of this agreement shall be considered as effective and valid as the original.

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. This also applies if your insurance company requests a refund of payments made to California Hand and Physical Therapy. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to California Hand and Physical Therapy.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I also agree to make payments for which I am responsible for in a timely manner. *The above may not apply directly to those that are considered Workers' Comp patients*. However, please be advised that if you claim Workers' Comp benefits and your benefits are denied you may be held responsible for the total amount of charges for services rendered to you. I also understand and agree that if I fail to make the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the balance owed, including court costs, collection agency fees, and attorney fees.

NOTICE OF NONDISCRIMINATION

Pursuant to TITLE IV of the Civil Right of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination, Act of 1975, Montana Rehabilitation Therapy does not discriminate in the provision of services on the basis of race, color, ethnicity, disability, or age.

CONSENT TO TREATMENT

I do hereby consent to such treatment by the authorized personnel of California Hand and Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I fully understand and agree to the above.

Patient Signature _____ Date _____

CALIFORNIA HAND & PHYSICAL THERAPY, INC

Notice of Patient Information Practices

USES AND DISCLOSURES OF HEALTH INFORMATION

California Hand & Physical Therapy uses your health information to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $0.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

PATIENT RIGHTS

The staff at California Hand and Physical Therapy has adopted the following list of patient rights, which shall include but not be limited to:

1. Exercise these rights without regard to sex or culture, economic, educational, or religious background or the source of payment for his/her care.
2. Considerate and respectful care including the appropriate assessment and management of pain.
3. Knowledge of the name of the therapist who has primary responsibility for coordinating his/her care, as well as the other therapists who will see him/her.
4. Receive information from his/her physician/therapist about his/her illness, his/her course of treatment, and his/her prospects for recovery in terms that he/she can understand.
5. Receive as much information about any proposed treatment or procedure he/she may need in order to give informed consent or to refuse. Except in emergencies, the information shall include a description of the procedure or treatment, the medically significant risks involved in retreatment, alternate course of treatment or non-treatment and the risks involved in each and know the name of the person who will carry out the treatment.
6. Participate actively in decision regarding his/her medical care to the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical care program, case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to his/her care. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9. Know which facility rules and policies apply to his/her conduct while a patient and leave the facility even against the advice of his/her physician.
10. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
11. Be advised if his/her physician proposes to engage in or perform human experimentation affecting his/her care or treatment and refuse to participate in such research projects.
12. Examine and receive an explanation of his/her bill regardless of source of payment.
13. Have all patients' right to apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

The care a patient receives depends partially on the patient. Therefore, a patient has certain responsibilities represented to them for mutual trust and respect.

PATIENT RESPONSIBILITIES

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health, including existing level of pain.
2. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment, and what is expected of him/her.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders. Therefore responsible for their actions, should they refuse treatment or not follow their physician's orders.
4. The patient is responsible for keeping appointments and for notifying our staff when he/she is unable to do so.
5. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
6. The patient is responsible for following facility policies and procedures and being considerate of the rights of other patients and facility personnel.

PROVIDER LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you are concerned that California Hand & Physical Therapy may have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Mayra Saborio PT, DPT, CHT / Owner ~ Phone (805) 604-1924

I have read and fully understand the *Notice of Patient Information Practices* and authorize use of my protected health information for purposes as stated above.

Patient Signature _____ Date _____

California Hand and Physical Therapy
Cancelation Policy

Dear Patients,

California Hand and Physical Therapy has an office policy for Late Cancelations and No show/Missed appointments.

Please provide our office with a 24 hour notice to change or cancel an appointment.

Answering machines are provided that you should use for after hours and on the weekends. 24 hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment.

- If 3 or more appointments are missed consecutively at any time during a patient's treatment, any further appointments already scheduled will be taken off the schedule.

A **$50 fee** will be applied for your "No-Show" or "Non 24-Hour" cancellations, and this will **NOT** be covered by your insurance.

Our Therapist have set times and are unable to fill slots for patients in need of an appointment if little to no notice is given.

Thank you for your cooperation.

I have read and understood the above policy.

_____ _____

Patient Signature Date

_____ _____

Front Office/Staff Signature Date

CALIFORNIA HAND & PHYSICAL THERAPY, INC

Patient Medical History

(Federal Regulations require a medical history must be included in all patients' medical records)

Patient Name _____ Age _____ Height _____ Weight _____

Referring MD _____ Date of symptoms or injury _____

Have you had any surgeries? Yes / No If yes, please list where performed and dates _____

_____

Females: Are you pregnant? Yes / No If yes, how long? _____

Do you now have, or have a history of any of the following?

Diabetes	Yes	No	Headaches	Yes	No
High blood Pressure	Yes	No	Sensitive to Heat/Ice	Yes	No
Heart Disease	Yes	No	Other Allergies	Yes	No
Hepatitis	Yes	No	Hernia	Yes	No
Pacemaker	Yes	No	Metal Implants	Yes	No
Seizures	Yes	No	Osteoporosis	Yes	No
Nervous Disorders	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Herpes / STDs / AIDS	Yes	No

If yes, on any of the above, please explain and give approximate dates:

_____

_____

Are you presently taking medications? Yes / No If yes, please list the medication(s) and dosage

_____

_____

Are you allergic to any medications? Yes / No If yes, please list the medication(s)

_____

_____

The above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

Contraindications for treatment due to medical history:

_____

_____

Therapist Signature _____ Date _____

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____