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

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 & 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 and Physical Therapy, Inc.

Dear Patient,

California Hand and Physical Therapy, Inc. has an office policy regarding late Cancellation and No Show appointments.

We require a 24-hour notice prior to cancellation in order to avoid a $25.00 fee. If you fail to cancel an appointment within 24 hours or no show for a scheduled appointment, you will be charged $25.00.

Our therapists have set times and are unable to fill their therapy schedule if no or little notice is given to reschedule.

Thank you for your cooperation.

I have read and received a copy of this policy.

_____ _____

Patient's signature Today's date

Physical Therapy History Form

Name:_____ **SSN:**_____ **Date:** _____

Leisure activities, including exercise routines: _____
Occupation, including activities that comprise your workday: _____
Age:_____ Height:_____ Weight:_____
Are you on a work restriction from your doctor? **Yes** **No**
Are you latex sensitive? **Yes** **No** Do you smoke? **Yes** **No**
Do you have a pacemaker? **Yes** **No**
FOR WOMEN: Are you currently pregnant or think you may be? **Yes** **No**
Allergies: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following? (check all that apply)

- o Fatigue
- o Fever/chills/sweats
- o Nausea/vomiting
- o Weight loss/gain
- o Difficulty maintaining balance while walking
- o Numbness or tingling
- o Muscle weakness
- o Dizziness/ lightheadedness
- o Heartburn/ indigestion
- o Difficulty swallowing
- o Changes in bowel or bladder function
- o Constipation/ diarrhea
- o Shortness of breath
- o Fainting
- o Cough
- o Headaches

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all the apply)

- o Cancer
- o Heart problems
- o High blood pressure
- o Depression
- o Diabetes
- o Stroke
- o Tuberculosis
- o Thyroid problems
- o Blood clots

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- o Cancer
- o Heart problems
- o Chest pain/angina
- o High blood pressure
- o Circulation problems
- o Blood clots
- o Stroke
- o Anemia
- o Depression
- o Epilepsy
- o Ulcers
- o Multiple sclerosis
- o Bone or joint infection
- o Chemical dependency (i.e.,alcoholism)
- o Lung problems
- o Tuberculosis
- o Asthma
- o Eye problems/ infections
- o Liver problems
- o Hepatitis
- o Rheumatoid arthritis
- o Kidney problems/ infection
- o Sexually transmitted diseases/HIV
- o Pelvic inflammatory disease
- o Thyroid problems
- o Diabetes
- o Osteoporosis
- o Pneumonia
- o Bladder/urinary tract infection

During the past month have you been feeling down, depressed or hopeless? **Yes** **No**
During the past month have you been bothered by having little interest or pleasure in doing things? **Yes** **No**
Is this something with which you would like help? **Yes** **Yes, BUT NOT TODAY** **No**
Do you ever feel unsafe at home or has anyone hit you or have tried to injure yourself in any way? **Yes** **No**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1._____ 3._____ 5._____
2._____ 4._____ 6._____

Have you ever taken steroid medications for any medical conditions? **Yes** **No**
Have you ever taken blood thinners or anticoagulant medications for any medical conditions? **Yes** **No**

Physical Therapy History Form

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

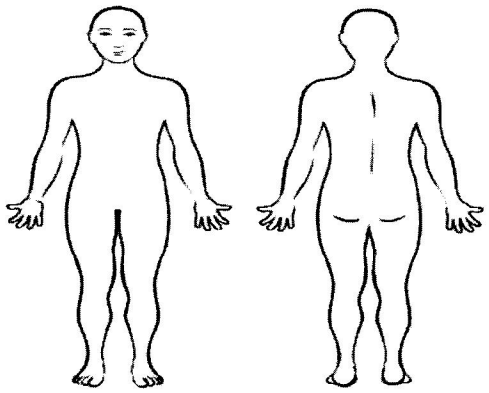
1. _____
2. _____
3. _____

What date (roughly) did your present symptoms start?_____
What do you think caused your symptoms? _____
My symptoms are currently? □Getting Better □Getting Worse □Staying About The Same
I should not do physical activities that might make my pain worse:
□ Disagree □ Unsure □ Agree
Treatment received so far for this problem (chiropractic, injections, etc.)_____
Please list special tests performed for this problem (X-rays, MRI, labs, etc.)_____
Have you ever had this problem before? **Yes** **No** When:_____
Treatment received:_____
How long did it take for you to feel better?_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
○ **Dull/aching pain**
lll **Numbness**
= **Tingling**



My symptoms currently:
□ **Come and go** □ **Are constant** □ **Are constant, but change with activity.**

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1._____
2._____
3._____
Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1._____
2._____
3._____
Do your symptoms affect your sleeping habits?
□ No problem sleeping □ Difficulty falling asleep □ Awakened by pain □ Sleep only with medication

When are your symptoms worse? □ Morning □ Afternoon □ Evening □ Night □ After exercise
When are your symptoms better? □ Morning □ Afternoon □ Evening □ Night □ After exercise

Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey:_____
The best your pain has been during the past 24 hours:_____
The worst your pain has been during the past 24 hours:_____