PHYSICAL THERAPY SPECIALTIES

Date: ______________

Patient Registration

PLEASE PRINT

LAST NAME _________________________________ **FIRST NAME**__________________________

ADDRESS____

CITY ____**STATE** _____________**ZIP** _____________

HOME PHONE _______-________-___________ **WORK/CELL PHONE** ________-______-____________

Okay to leave message? ____ Yes ____ No Okay to leave message? ____ Yes ____ No

How would you like Appointment Reminders? ___ Hm Phone ___ Cell Phone ___ E-Mail ___ Text

E-MAIL ADDRESS: ____

DATE OF BIRTH _________-_________-_________ **AGE** _____________________

SEX ______________________

SPOUSE' NAME _________________________ **SOCIAL SECURITY #** _______-_______-________

EMPLOYER NAME _________________________________ **PHONE** ___________________________

(LIST SPOUSE INFO IF NOT CURRENTLY WORKING)

ADDRESS ____

EMERGENCY CONTACT ____________________________________**PHONE** _____-_____-__________

RELATION ____

PRIMARY CARE PHYSICIAN: _________________________________

REFERRED BY: ____ **PHONE** ______-______-___________

Date of Injury ____-____-____

HOW DID YOU HEAR ABOUT US? __MD __ Friend/Family __Internet __Website __Class __Other

FORM OF PAYMENT: (*Circle one*) **PRIVATE INSURANCE WORK COMP SELF PAY AUTO**

If Work Comp, Employer at time of injury __________________________Phone _____-_____-__________

IS THERE A SECONDARY INSURANCE? ____

WHO WILL BE RESPONSIBLE FOR THE BILL? ____

* *

ASSIGNMENT OF BENEFITS

I understand that payment for service is expected at the time service is rendered unless my insurance is to be billed. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Physical Therapy Specialties to release all information necessary to secure the payment of benefits. I authorize my insurance benefits to be paid directly to Physical Therapy Specialties.

SIGNATURE ______________________________________**DATE** ____________________________

* *

PHYSICAL THERAPY SPECIALTIES

Date: _____

Health History

1. Do you have any of the following Medical Conditions? ***Please circle Yes/No***

GENERAL MEDICAL CONDITIONS:

Arthritis	Yes	No	Allergies (type)_____		
Anxiety/Panic Disorders	Yes	No	Back Pain (neck pain, low back pain, degenerative disc disease,		
Cancer	Yes	No	spinal stenosis)	Yes	No
Depression	Yes	No	Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall		
Headaches	Yes	No	gall bladder)	Yes	No
Hepatitis/AIDS	Yes	No	Kidney, bladder, prostate, or urination		
Incontinence	Yes	No	Problems	Yes	No
Osteoporosis	Yes	No	Prosthesis/Implants	Yes	No
Previous accidents	Yes	No	Hearing impairment		
Sleep Dysfunction	Yes	No	(hard of hearing, even with hearing aids)	Yes	No
Numbness/tingling in arms/legs	Yes	No	Visual Impairment	Yes	No
Neurological Disease			(such as cataracts, glaucoma, macular degeneration)		
(i.e. MS or Parkinson's)	Yes	No			

Falls within the past year *(only if yes, fill out the Fall Assessment page)* **Yes** **No**

PriorSurgery(s)_____

Infection, please describe _____

Recent fractures (broken bones) if so please list _____

Serious injury, explain _____

Allergies to medication, if so please list _____

Major surgery, type _____

Currently pregnant, if so how many weeks _____

List any other history or medical conditions or illnesses _____

_____

_____

HEART DISEASE

Angina	Yes	No	Angioplasty/Coronary Artery Bypass Graft (CABG)	Yes	No
Arrhythmia	Yes	No	Pacemaker	Yes	No
Congestive Heart Failure (CHF)	Yes	No	Taking Blood Pressure Medication	Yes	No
Heart Attack/Myocardial Infarction (MI)	Yes	No	Valvular Disease	Yes	No
Pacemaker	Yes	No	Heart Problem (other):	Yes	No
High Blood Pressure	Yes	No	please describe**:** _____		

LUNG DISEASE

Asthma	Yes	No	Chronic Obstructive Pulmonary Disease (COPD)	Yes	No
Emphysema	Yes	No	Acquired Respiratory Distress Syndrome (ARDS)	Yes	No
Recent Pneumonia	Yes	No			

VASCULAR DISEASE

Diabetes	Yes	No	Peripheral Arterial Disease	Yes	No
Stroke/TIA	Yes	No			

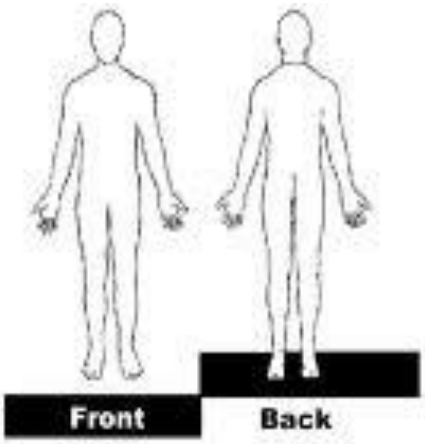
PHYSICAL THERAPY SPECIALTIES

Date: _____

Health History - PAGE 2

1. Height: _____ Weight: _____

2. Please indicate on the diagram below the location of your pain and describe the type of pain (sharp, dull, aching, shooting, etc.)



3. How did the injury occur?_____

_____

4. Please rate your pain at its lowest, average and highest.
PAIN SCALE: 0-no pain, 1-2-Mild, aware of the pain only when attention is brought to the area. 3-4-Discomforting pain, which may be ignored. 5-Discomforting pain which may be distracting. 6-Distressing pain, but able to perform most tasks. 7-8-Intolerable pain, concentration is difficult, able to perform some tasks. 9-10-Intolerable pain and hospital care is required.

0 1 2 3 4 5 6 7 8 9 10

5. Is your pain: increasing? _____ decreasing? _____ same? _____

6. Have you already received treatment for this problem at other locations? (Please circle)

Medical Doctor	yes	no	Chiropractor	yes	no
Physical Therapist	yes	no	Dentist	yes	no
Psychologist	yes	no	Other _____		

7. What test(s) or treatment(s) have you had concerning this problem? Please check

_____	X-Ray	_____	Myelogram
_____	CT Scan	_____	Cortisone Injections
_____	MRI	_____	Biofeedback
_____	EMG	_____	Other, please explain _____

8. Have you had a similar problem in the past? yes no

9. Are you currently working? yes no If no, last day worked: _____

10. Is there anything else you would like to tell us? _____

_____

PHYSICAL THERAPY SPECIALTIES

Date: _____

Medication Record

Patient Name: _____

Please list all prescriptions, over-the-counter medications, and supplements:
I am taking Vitamin D: ☐ Yes ☐ No

Medication	Dosage	Times per day	Route: (Mouth, injection, patch, etc.)

Date	Changes (dosage changes, discontinued/added medications)	Initials

PHYSICAL THERAPY SPECIALTIES

Date: _____

Consent Form

The following is a list of modalities and procedures used in physical therapy. Your physical therapist will explain which ones will be used during your treatment, discuss treatment alternatives, and goals of treatment with you.

Evaluation
Heat
Ice
Electrical Stimulation
Massage and Muscle Release Techniques
Postural Training
Functional Training
(Body mechanics, Activities of Daily Living)
Ultrasound
Joint Mobilization
Joint Manipulation
Muscle Stretching
Traction
Therapeutic Exercise
Iontophoresis
Biofeedback Training

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Our office employs both male and female therapists. Please communicate with our office staff if the gender of your therapist is important to you.

Comments: _____

_____

Consent for Treatment

I give my consent for treatment by the health care professional staff of Physical Therapy Specialties to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Physical Therapy Specialties. I further understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to the results of treatment.

Patient Signature _____ Date_____

Therapist Signature _____ Date _____

PHYSICAL THERAPY SPECIALTIES

Date: _____

Credit Policy

Our credit policy has 3 options. Please check one of the following

_____ Option 1: You may **self pay** (cash, check or credit card) for each visit which entitles you to a discount. Pay for services is required when rendered, unless other arrangements have been made in advance. Please be prepared to pay for each visit at the time of service.

_____ Option 2: **Work related injury**. Worker's compensation insurance will be billed. No payment is collected from you. Services for industrial injuries must have prior authorization by the industrial carrier. You will be informed if any difficulties in obtaining authorization are encountered. The patient is responsible for all fees should the industrial insurance company deny authorization for treatment.

_____ Option 3: **Private Insurance**:
If your bill is to be paid by a third party, for example an insurance company, it is required that you sign an Assignment of Benefits (See Patient Registration) so that the insurance company can pay us directly. It will be your responsibility to pay the portion of your bill not covered by your insurance company at the time of service (example: deductible, co-payment, share of cost 20%, etc.). The patient is ultimately responsible for all fees regardless of insurance coverage. We will make every effort to provide only those services considered medically necessary by your insurance plan, unless your express permission is given in writing. Should your insurance plan deem that services are not medically necessary, you will be responsible for the charges.

I understand that it is my responsibility to follow the guidelines and to know the coverage and benefits of my medical insurance plan. If I am a member of a managed care program, it is my responsibility to notify Physical Therapy Specialties that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for all services for which I have not obtained a valid referral. I further agree that a photocopy of this agreement shall be as valid as the original.

Note: **24 hour notice is required to cancel an appointment. If notice is not given you may be subject to a late cancellation charge of $50.00. You will be charged the $50.00 fee if you fail (or "no show") to keep your appointment.**

I have read the above, understand it and agree to it.

_____ _____

Signature Date

PHYSICAL THERAPY SPECIALTIES

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Physical Therapy Specialties reserves the right to modify the privacy practices outlined in the notice. I understand that Physical Therapy Specialties may contact me to remind me of appointments or to discuss any other health related manner.

_____ _____
Signature Date

_____
Print Name

_____ _____
Signature of Patient Representative Date
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Privacy practices are posted in our reception area. A copy is available for you to review at any time by asking the Receptionist. We are diligent in ensuring client privacy is maintained at all times.

PHYSICAL THERAPY SPECIALTIES

Date: _____

Fall Assessment

Please circle yes or no

1. Have you sustained an injury from a fall? Yes No
2. Have you had two or more falls in the past year? Yes No

If no to #1 and #2, stop

3. Do you have any of the following in your home? Please select all that apply:

____ Clutter where you walk
____ Exposed electrical cords
____ Furniture or other sharp edged items in the normal pathways through your house
____ Poor lighting
____ Raised doorway thresholds
____ Slippery floors
____ Steps and stairways
____ Throw rugs

4. Medications
   - Was there a change in your listed medications at the time of fall? Yes No
   - If yes, please list changes:

Medication	Dosage

PHYSICAL THERAPY SPECIALTIES

Date: _____

Health History - PAGE 3

Only required for those seeking TMJ treatment

DENTAL BACKGROUND

11. Do you have a regular dentist? yes no
If so, do they know you are being seen here? yes no

Dentist's Name _____ Telephone_____

12. How much dental work have you had? ___ Extensive _____ Routine _____ Minimal

13. Would you say your mouth is: ___ Healthy ____ Average ___ Has many problems

14. Is your bite comfortable? yes no

15. Please check all of the following types of dental care you may have received:

_____ Endodontics (Root canal)
_____ Orthodontics
_____ Oral Surgery
_____ Dental Implants
_____ Periodontics (Treatment of gums)
_____ Extensive Bit Adjustment
_____ Dentures or Partials

16. Please check any of the symptoms that you are experiencing. Your therapist will go over them with you.

_____ Difficulty opening / closing mouth or eating
_____ Headache
_____ Jaw pain
_____ Neck pain
_____ Jaw joint clicking
_____ Jaw joint locking
_____ Tooth pain
_____ Facial pain
_____ Ear pain
_____ Ear buzzing or ringing
_____ Lower back pain
_____ Other (Specify) _____
_____ Eye pain
_____ Blurred vision
_____ Sinus pain
_____ Frequent runny nose
_____ Scalp pain
_____ Clench or grind teeth
_____ Dizziness
_____ Changes in hearing
_____ Upper back pain / Chest pain
_____ Arm pain / Numbness

PHYSICAL THERAPY SPECIALTIES

Date: _____

Patient Electronic Communication Consent Form

Physical Therapy Specialties (PTS) offers patients the opportunity to communicate by email. Sending patient information includes several risks of which the patient should be aware. The patient should not agree to communicate with PTS staff via email without understanding and accepting these risks.
The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
Standard e-mail services, such as Gmail, AOL, Yahoo and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals.
Transmitting e-mail that contains protected health information through an email system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act (HIPAA).
Your e-mail address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipients e-mail addresses will be hidden.

Provider Responsibilities

All e-mail/text communication with patients is sent via a non-encrypted service, therefore information is not secure.
Your provider may route your e-mail messages to other members of the staff for informational purposes or for expediting a response.
Designated staff may receive and read your e-mail.
Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.
Emails will be utilized for insurance verification, surveys, as well as appointment reminders and scheduling.
The provider will attempt to electronically confirm your e-mail address by requesting a return response to all email messages.

Patient Responsibilities

E-mail messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office, via telephone.
Please key in your full name and the topic, i.e., home program question, in the subject line. This will serve to identify you as the sender of the e-mail.
Please acknowledge that you received and read the provider's message by return e-mail to the provider.
I have read and understood the above description of the risks and responsibilities associated with the electronic communication with my healthcare provider.

PHYSICAL THERAPY SPECIALTIES

Date: _____

I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.
I understand that I may revoke my consent to communicate electronically at any time by notifying Physical Therapy Specialties in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.
I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secured network.
I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT_____

Patient Authorized E-mail Address _____

Patient Signature_____

Date_____

Patient Representative (if applicable) _____

Patient Representative E-Mail Address _____

Patient Representative Signature_____

Date_____

PHYSICAL THERAPY SPECIALTIES

Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, Progress Notes and/or Progress Reports will be available in your medical record and copies forwarded to all health professionals who may provide treatment or who may be consulted by staff members, including your treating physician and/or nurse case managers where applicable.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated, and corresponding Progress Notes/Reports.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Physical Therapy Specialties**. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosures of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment reminders. Your health information will be used by our staff to contact you for appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

PHYSICAL THERAPY SPECIALTIES

Date: _____

PHYSICAL THERAPY SPECIALTIES DUTIES:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Ida Hirst. Your request will be review and generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Ida Hirst
Physical Therapy Specialties
3908 Valley Ave., Suite B
Pleasanton, CA 94566

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:

Ida Hirst
Physical Therapy Specialties
3908 Valley Ave., Suite B
Pleasanton, CA 94566

EFFECTIVE DATE

This Notice is effective on or after April 1, 2003