First Step Physical Therapy

Patient History

Name:	**Age:**
Occupation: Working Currently: Yes / No / Retired ☐ Normal duty ☐ Limited duty?	

Where is your problem? (please circle)
Shoulder Knee Elbow
Neck Back Other
Dominant Arm? Right / Left
Problem(s) (please check /circle all that apply):
- ☐ Pain?
- ☐ Weakness / Instability / giving way?
- ☐ Dizziness / Headache / Numbness?
- ☐ Stiffness / Fatigue?
- ☐ Swelling./ Deformity?
- ☐ Other

How long have you had symptoms?
Days Months Yrs

Have you ever had this problem before? Yes No

Current Medications (for):

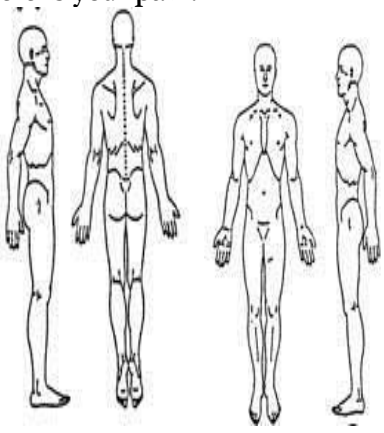
How did you injure yourself?
- ☐ No injury – just started hurting
- ☐ Sports (which sport?)
- ☐ Motor vehicle accident
- ☐ Work / job

Please briefly describe the injury:

If involved in a motor vehicle accident:

You were: Driver Passenger Pedestrian
You were struck from Back Front Left side Right side
You were taken to a hospital? No / Yes
You were lost consciousness? No / Yes

Where is your pain?



How severe is your pain?
1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

Aggravating factors:

Easing factors:

Your Current Limitations:

Have you had any X-rays: No / Yes Date:
SCAN/MRI No / Yes Date:

Allergies? **Medical History: (please circle)** Do / did you have any heart problems? No / Yes Do / did you have any Arthritis? No / Yes Do / did you have diabetes? No / Yes Do / did you have High Blood Pressure? No / Yes Do / did you had any recent Surgery? No / Yes Do / did you had any other fall/injury? No / Yes Do / did you have cancer? No / Yes Do / did you smoke? No / Yes	**You live in:** Apartment_ _ _House._ _ [Any stairs_ _ _ _] **You live:** Alone_ _ _ Spouse and/or others_ _ _ _ **Do you exercise regularly?** _ _ _ Yes _ _ _No **Sports level:** None / Recreational / College / Professional **Goals from Physical Therapy program:** **Rate Your Health:** **Good Fair Poor**

I understand that my candidacy for Physical Therapy Rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The Physical Therapist will determine whether or not I am a viable candidate for Physical Therapy treatment.

Signature: ---------- Date: - - / - - /- -

First Step Physical Therapy
New Patient Information

Name: _____ Date _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home( ) _____ Work ( ) _____ Cell ( ) _____

DOB. ____/____/____ SS #: _____Sex: M___ F___Drivers License#_____

Emergency Contact_____ Phone: ( ) _____ Relationship_____

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Financially Responsible Party Information

Name: _____ Phone: ( ) _____ Relation: _____DOB_____

Address: _____ City: _____ State: ____ Zip: _____

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Patient Employer Information

Employer Name_____ Phone ( ) _____

Address_____City _____State_____Zip_____

Occupation_____ Work Related Injury Yes___ No _____ Auto Related Yes____No_____

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Referring Physician: _____NPI#_____

Phone( ) _____Address _____ City_____ State_____ Zip:_____

Diagnosis: _____ ICD.9 Code: _____DOI:____/____/_____

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Insurance Information

(Please give insurance card(s) to the receptionist.)

If not Patient Insured Name_____DOB____/____/_____ Phone ( )_____

Address_____City_____State _____Zip_____

Employer _____Relationship to Patient_____

Primary Insurance _____Phone _____

ID# _____Group _____

Secondary Insurance _____Phone _____

Insured Name _____DOB_____ID# _____Group _____

The above information is true and correct to the best of my knowledge. I authorize First Step Physical Therapy to release and/or request information to/from insurance companies and all medical providers needed for treatment and to process claims. I authorize assignment of benefits directly to First Step Physical Therapy. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for any unpaid balances.

_____ _____

Patient/Guardian Signature Date

First Step Physical Therapy
1000, Sunrise Avenue,
Suite 6A
Roseville, CA – 95661.
Ph: (916) 786-7837
Fax: (916) 786-7844

Informed Consent

Conditions & Consent for Physical Therapy

I understand that I am a patient of ***First Step*** Physical Therapy, a private, therapist owned Physical Therapy practice.

Cooperation with Treatment: In order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy Program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Cancellation Policy: I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined by my plan of care. Furthermore, I understand that if I cancel more than 12 hours in advance I will not be charged. I understand that if I cancel in less than 12 hours in advance I will pay a cancellation fee of $25.00 to be paid at the time of my next appointment as that time could have been given to another patient.

Limitations: I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment: I understand 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.

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

Potential Benefits: I understand I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: I understand that 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.

Financial and Insurance Responsibilities: I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient physical therapy benefits. I understand ***First Step*** Physical Therapy will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information ***First Step*** Physical Therapy receives is accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my therapist, or ***First Step*** Physical Therapy for further assistance.

I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment.

_____ _____

Print Name Date

_____ _____

Patient/Parent (Guardian) Witness
Signature if patient is under 18 years of age

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION.

We are committed to protecting your medical information, when you are referred to our facility by your physician, a medical change is created to record your treatment. This notices tells you how that information may be used, when and how your records may be disclosed, and what your rights are regarding your medical records.

Use and Disclosure of Your Medical Information:

For Treatment: We may use medical information about you to provide treatment and services. We may disclose medical information about you to therapists, assistants, aides, students, and others who are involved in taking care of you at the facility. We may also disclose information to your referring physician or outside healthcare provider involved in your treatment.

For Payment: We may use and disclose medical information about you in order to bill an insurance carrier or provide information to your attorney for settlement of a legal case.

For Health Care Operations: We may use and disclose medical information about you for company quality assurance activities and staff training. Your medical information may also be used or disclosed to comply with law and regulation, for contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of the company to another entity, underwriting and other insurance activities.

Appointment Reminders: We may contact you to remind you that you have an appointment at our facility.

As Required By Law: We will disclose medical information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safely or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Workers' Compensation: We may use of disclose medical information about you for Workers Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures: We may disclose medical information about you for public health purposes. These purposes generally include the following:

- Preventing or controlling disease (such as cancer and tuberculosis), injury or disability.
- Reporting vital events such as births and deaths.
- Reporting child abuse or neglect.
- Reporting adverse events or surveillance related to food, medications or defects or problems with products.
- Notifying persons of recalls, repairs or replacements of products they may be using.
- Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Reporting lo the employer findings concerning a work-related illness or injury or workplace-related medical surveillance.
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities: We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Legal Proceedings: We may disclose medical information to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

Lawsuits and Other Legal Actions: In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement: lf asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- About a death suspected to be the result of criminal conduct
- About criminal conduct at any of our facilities
- In case of a medical emergency, to report a crime, the location of the crime or victims, or the identity, description or location or the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information to a coroner or medical examiner.

National Security and Intelligence Activities: As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities.

Protective Services for the President and Others: As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates: if you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical information is the property of First Step Physical Therapy. The following are your rights to those records.

Right to Inspect and Copy: You have the right to inspect and/or receive a copy of your medical information that was generated from this facility. There may be a fee for copying records.

Right to Request an Amendment or Addendum: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by First Step Physical Therapy. All requests must be in writing.

Right to an Accounting of Disclosures: You have the right to receive a list of certain disclosures we have made of your medical information after April 15, 2003. All requests must be in writing.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. All requests must be in writing.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO PRACTICES AND THIS NOTICE

We reserve the right to Change these privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at this facility with the effective date.

QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact (916) 786 - 7837. If you believe your privacy rights have been violated, you may file a complaint with the above address.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

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Signature **Date**