5919 Bldg A Hollis St, Emeryville, CA 94608 ✦ Phone: (510) 923-0700 ✦ Fax: (510) 923-0500

PATIENT INFORMATION

*Patient Name:_____ Male Female *Preferred Noun:_____

*Address:_____ *Date of Birth:_____

*City:_____ *State:_____ *Zip Code:_____

***REMINDER NOTIFICATION PREFERENCE (PLEASE CHECK ONE):** ☐ **TEXT** ☐ **PHONE CALL**

*Home Phone:_____ *Cell Phone:_____

*Email Address:_____

*Social Security #:_____ *Referring Doctor:_____

Location of pain/injury:_____ Injury Date:_____ Surgery Date:_____

Employer:_____ Occupation:_____

*Emergency Contact:_____ *Relation to Patient:_____ *Phone:_____

If patient is not the subscriber on insurance:

Subscriber Name: _____ Date of Birth:_____

*Relation to Patient:_____ *Subscriber's SSN # (Tricare ONLY): _____

I give permission to Pacific Orthopaedic & Sports Rehabilitation to release information to my insurance company, attorney, assignees and/or beneficiaries. I authorize payment directly to Pacific Orthopaedic & Sports Rehabilitation for services that I or a dependent has received by my insurance carrier. In consideration of their services rendered and to be rendered to the above named patient by Pacific Orthopaedic & Sports Rehabilitation, I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by my insurance carrier.

- **I understand Pacific Orthopaedic & Sports Rehabilitation will verify benefits and coverage with my insurance carrier, but this does not guarantee payment by my insurance carrier.**
- **I understand I will be liable for reasonable collection fees, interest and other costs for unpaid debt incurred.**
- **I understand Pacific Orthopaedic & Sports Rehabilitation has a 24 hour cancellation policy and I will be liable for $75 No Show/Late Cancellation Fee for repeat offenses of this policy prior to any further appointment schedule.**
- **Failure to arrive within 15 minutes of my scheduled appointment may result in the inability of the clinic to provide services to me that day.**

Signature of Patient or Parent/Guardian:_____

Print Name:_____ Date:_____

Name:_____ **Date of Birth:**_____

PRESENT CONDITION

Is this a work related injury?	Is this injury from a car accident?	Have you received physical therapy treatment this year?	Are you currently receiving Home Healthcare via Medicare this year?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant? Yes No If yes, when is the baby due?_____

Chief Complaint:_____

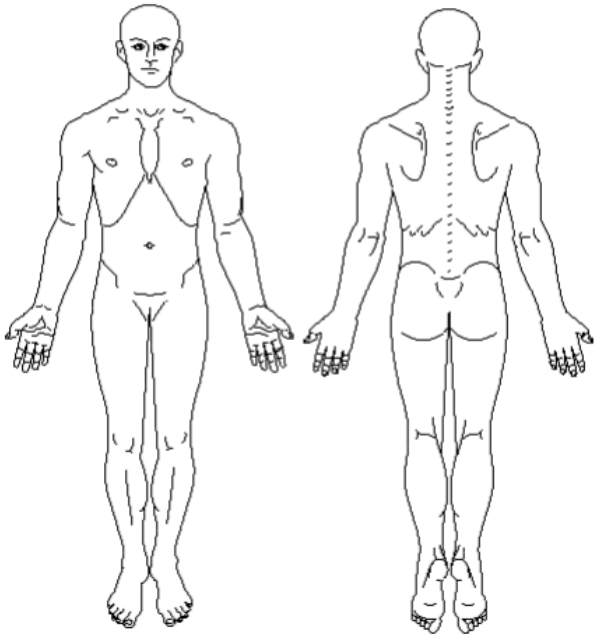
_____

_____ Date of injury/onset:_____

History of injury/onset:_____

_____

Please place an "**X**" in the area/areas where you are experiencing your pain/symptoms:



Please pick the words that best describe your pain:

☐ Severe	☐ Burning	☐ Sharp	☐ Dull
☐ Numbness/tingling	☐ Radiating	☐ Throbbing	☐ Stabbing
☐ Ache	☐ Moderate	☐ Weakness	

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain):

Current (0-10):	Worst: (0-10):	Best (0-10):

What makes your symptoms better? (i.e. stretching, heat, ice, rest, etc)_____

_____

What makes your symptoms worse?_____

_____

What do you expect to accomplish with physical therapy?_____

_____

Have you had any imaging performed related to this condition:

☐ X-Ray	☐ MRI	☐ CT Scan	☐ Doppler	☐ Ultrasound	☐ Other

Other:_____

Work/Recreation

Are you currently working?	If yes, how many hours per week?	Occupation:	Full or Light Duty?
☐ Yes ☐ No			

Please describe the physical demands of your job (i.e. lifting, prolonged sitting, computer work, pushing, pulling):_____

_____

Current activity level/Exercise routine (if any):_____

_____

Recreational activities:_____

_____

Falls

Have you had any falls within the past year?	If yes, how many? Please describe, including injuries:
☐ Yes ☐ No	

Any unexplained dizziness?	If yes, please describe:
☐ Yes ☐ No	

CURRENT/PAST MEDICAL HISTORY

Please check any current or previous medical history:

☐ Allergies	☐ Depression	☐ Kidney Disorders	☐ Seizures
☐ Anemia	☐ Diabetes	☐ Metal Implants	☐ Strokes
☐ Aortic Aneurysm	☐ Emphysema	☐ Osteoporosis	☐ Thyroid
☐ Arthritis	☐ Headaches	☐ Pacemakers	☐ Ulcers
☐ Asthma	☐ Heart Attack	☐ Prostate Problems	☐ Other:_____
☐ Blood Pressure (High or Low)	☐ Heart Condition	☐ Rapid Heart Beat	_____
☐ Cancer	☐ Hernia		

Allergies (including latex):_____

_____

List any surgeries or hospitalization (with year):_____

_____

_____

List current medications (prescription, OTC, supplements):_____

_____

_____

Patient Therapy Participation, Attendance and Consent Agreement

Your health and well-being are of the utmost importance to us. We are committed to providing you with the highest standard care, and your cooperation is essential to achieving the best possible outcome. Your physician has prescribed therapy for the treatment of an injury or medical condition. Please understand that recovery is a gradual process that requires your active participation and consistent commitment.

Patient Responsibilities

Please read each statement carefully and initial to acknowledge your understanding and agreement:

_____***(Initials)*** I understand that to maximize the benefits of therapy, I am expected to fully cooperate and actively participate in all prescribed activities and exercises designed to improve my overall physical health. I will perform these activities under professional supervision and follow the treatment plan established by my therapist.

_____***(Initials)*** I agree to arrive on time for all scheduled appointments. I understand that late arrival may result in a shortened session or rescheduling. Therapy sessions will not be extended due to tardiness. Arriving 15 minutes or more late may result in cancellation of my appointment unless scheduling availability permits otherwise.

_____***(Initials)*** I understand that consistent attendance is essential to my progress. Excessive absences or poor attendance may result in discharge from treatment. I acknowledge that missed appointments affect both my care and the clinic's ability to serve other patients.

_____***(Initials)*** I understand that failure to attend 2 scheduled appointments without prior notice ("no-call, no-show") will result in discharge from therapy services, and my referring physician may be notified.

_____***(Initials)*** I agree to provide at least 24 hours' notice for any appointment cancellation. Failure to do so may result in restrictions on advance scheduling, including placement on a same-day scheduling basis and cancellation of future appointments.

_____***(Initials)*** I understand that appointments not canceled at least 24 hours in advance may incur a cancellation fee of $75. I acknowledge that, while reminders may be provided as a courtesy, it is my responsibility to keep track of all scheduled appointments.

Consent for Treatment

I have been informed by Pacific Orthopaedic & Sports Rehabilitation of the treatment and care prescribed by my physician. I understand that, as a patient, I remain under the care and direction of my physician, and Pacific Orthopaedic & Sports Rehabilitation will provide services in accordance with my physician's instructions.

I acknowledge and agree that Pacific Orthopaedic & Sports Rehabilitation shall not be held liable for any act or omission in the course of providing treatment consistent with my physician's orders.

I further understand and acknowledge that no guarantee or assurance has been made regarding the outcome or results of the prescribed treatment.

Signature of Patient or Parent/Guardian:_____ Date:_____

Patient Name:_____ Parent/Guardian Name: _____

It is ultimately your (the patient) responsibility to know what the amount of your insurance deductible and copay/coinsurance is. If you do not know or are unsure of what it may be, we will be happy to assist you to provide whatever information that your insurance carrier provides us. We take no responsibility for the accuracy of the information your insurance carrier provides to us. If you disagree with any of the information we have provided you, please contact your insurance immediately. We are providing this notice for you to be aware of what you may owe for any treatments you receive at our facility.

To be clear, being "covered" means that you are covered under the terms and limits of your insurance plan. It does not mean your insurance will pay everything or anything. You are still liable for your deductible, copay, coinsurance or any payments your insurance denies.

Deductible:

(A deductible is the amount that must be paid out of your pocket before your insurance will cover or pay for any services outside of a general visit to your doctor)

Copay:

(A copay is a flat amount that you are responsible for on each date of services)

Coinsurance:

(A coinsurance is usually a percentage of the cost that the patient is responsible for)

Please sign below to acknowledge you have read and understand the above. We will provide you with a copy, if requested.

_____ _____

Signature Date

_____

Print Name

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed how you can get access to this information.

Please review it carefully.
The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about your privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 12/15/2008 and will remain effective until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we do so.

Person Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person”s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal Officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request for copies, we will charge you $0.10 for each page, $30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structures.

Disclosing Accounting

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication

You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your requests in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment

You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us by using the contact information listed at the end of this notice. You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint, upon your request. We support your right to privacy of your health information. We will not retaliate in any way, if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer:	Nathan Sanchez
Telephone:	(510) 923-0700
Fax:	(510) 923-0500
Address:	5915 Bldg A Hollis St Emeryville, CA 94608

_____	_____	_____
Signature	Date	Print Name