PATIENT INFORMATION
PACKPHYSICAL THERAPY

PLEASE PRINT CLEARLY

Date: _____

Name (Last)_____ (First) _____ (M.I) _____

Nickname _____ Email Address _____

Birth Date_____ Social Security_____ Age _____ Sex: M / F

Home Address _____ Apt/Unit____

City _____ **State**_____ **Zip** _____

Home Phone (____)_____ Cell Phone(____)_____Work Phone(____)_____

Preferred method of contact (circle one): **Home / Cell / Work**

Emergency Contact: Name_____ Relation_____

Address_____ Phone_____

Complaint/Area to be treated_____

Status Married / Single / Divorced / Separated / Widowed

Employment Full-time / Part-time / Not Working / Retired **Employer _____**

Student Status Full-time / Part-time / None

Injury Date_____ Date First Consulted _____

Referring Doctor_____

Who may we thank for your referral other than your Doctor?_____

Injury Type Work / Auto / Home / Other _____ Lawyer Involved Yes / No

Attorney Name _____ Telephone # (____)_____

By signing below, I certify that the above information is true and accurate to the best of my knowledge.

Patient/Guardian Signature:_____Date:_____

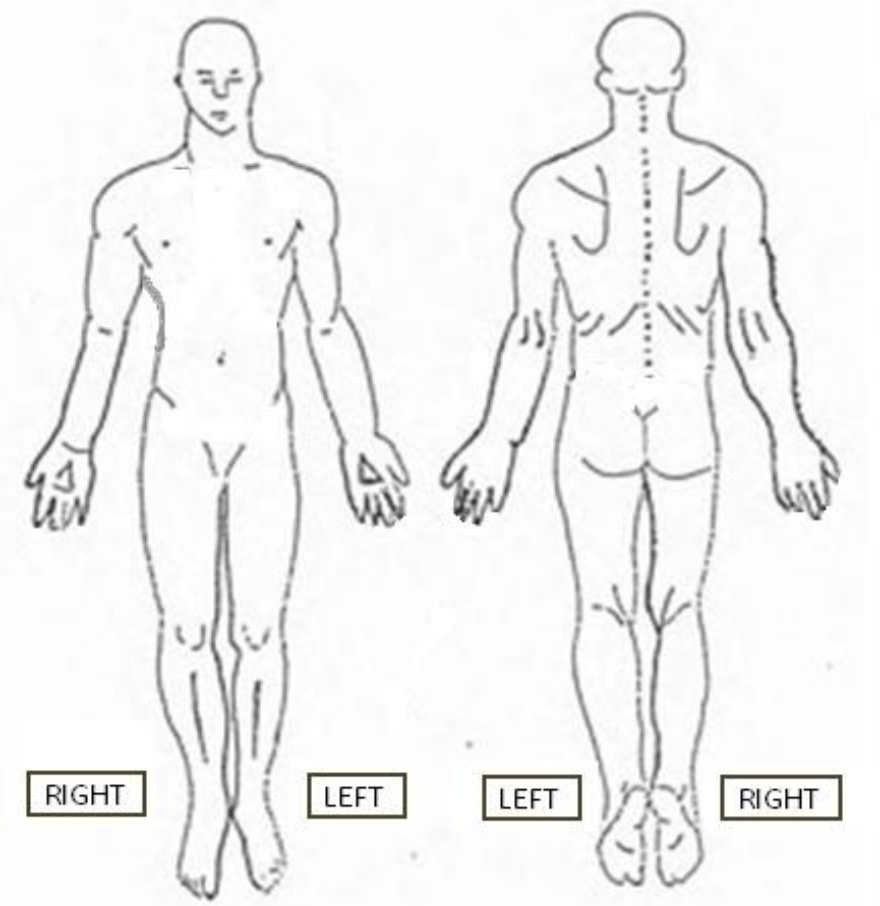
Please complete ALL information on the attached forms

PAIN DRAWING

PLEASE READ INSTRUCTIONS CAREFULLY

NAME: _____ DATE_____

PLEASE BE SURE TO FILL THIS OUT EXTREMELY ACCURATE. MARK THE AREA ON YOUR BODY WEHERE YOU FEEL THE DESCRIBED SENSATION(S). **USING THE APPROPRIATE SYMBOLS,** MARK THE AREAS OF PAIN, INCLUDE ALL AFFECTED AREAS, **AS YOU FEEL RIGHT NOW.** YOU MAY DRAW IN THE FACE AS WELL.



KEY

Numbness

Pins & Needles
OOOOOOOOOOOOOOOO

Burning
XXXXXXXXXXXXXX

Stabbing Pain
/ / / / / / / /

Aching Pain
((((((((

CURRENT COMPLAINT

I have: constant / intermittent / occasional / shooting / burning / aching / sharp / dull

Pain in my: left / right (area of body)

Pain scale: (circle one) 1 2 3 4 5 6 7 8 9 10 (*1 being no pain, 10 being emergency room visit)

Frequency & Duration of pain: _____

I also have:

Numbness in my _____

Tingling in my _____

Weakness in my _____

Headaches occurring _____

These specific activities **INCREASE** my pain: _____

These specific activities **DECREASE** my pain: _____

MEDICAL HISTORY SCREENING FORM

PACK PHYSICAL THERAPY

NAME: _____

DATE: _____

Circle YES or NO

Have you or any immediate family member ever been told you have:	**SELF**	**FAMILY**
Angina/chest pain	Yes ....No	Yes .....No
Cancer	Yes ....No	Yes .....No
Diabetes	Yes ...No	Yes .....No
High blood pressure	Yes ...No	Yes .....No
Heart disease	Yes ....No	Yes .....No
Multiple Sclerosis	Yes….No	Yes…..No
Osteoporosis	Yes ...No	Yes .....No
Osteoarthritis	Yes ....No	Yes .....No
Rheumatoid arthritis	Yes ....No	Yes .....No
Stroke	Yes ....No	Yes .....No
Thyroid problems	Yes….No	Yes…..No
Tuberculosis	Yes….No	Yes…..No
Fibromyalgia	Yes….No	Yes…..No

In the past 3 months have you had or are you currently experiencing:

A change in your health	Yes	No
Changes in appetite	Yes	No
Changes in bowel or bladder	Yes	No
Depression	Yes	No
Difficulty sleeping	Yes	No
Dizziness	Yes	No
Fever/chills/sweats	Yes	No
Nausea/Vomiting	Yes	No
Numbness or tingling	Yes	No
Shortness of breath	Yes	No
Under stress	Yes	No
Unexplained weight change	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No

List of medications currently using: _____

_____

_____

Additional Information:_____

_____

_____

_____

Circle YES or NO

Do you have a history of:

Allergies/Asthma	Yes	No
Anemia	Yes	No
Blood thinning medication	Yes	No
Bronchitis	Yes	No
Domestic violence	Yes	No
Headaches	Yes	No
Hepatitis	Yes	No
Kidney disease	Yes	No
Rheumatic fever	Yes	No
Recreational drug use	Yes	No
Ulcers	Yes	No
Sexually transmitted disease	Yes	No
Seizures	Yes	No
Steroid medication	Yes	No
Unexplained falls	Yes	No

Are you currently?

Pregnant	Yes	No
Depressed	Yes	No
Under Stress	Yes	No

Are your symptoms: (check one)

☐ Getting Worse ☐ Same ☐ Improving

At night, you sleep…: (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision ☐ Communication
☐ Speech ☐ Swallowing ☐ Balance

Have you smoked or chewed tobacco in the past?

☐ No
☐ Yes, _____Packs per day. _____Years_____

Do you drink alcoholic beverages?

☐ No ☐ Yes, _____Drinks per week.

Date of last physical examination: _____

Please list any operations that you've had and the date(s):

Operation	**Date:**

Do you have a pacemaker, transplated organ, joint replacements, or metal implants?

YES / NO

CONSENT TO TREATMENT OF A MINOR

PACK PHYSICAL THERAPY

I, _____, as a parent and/or legal guardian, authorize **PACK PHYSICAL THERAPY** to treat the minor/patient named below while I am not present.

_____ _____

Guardian/responsible party **Date**

_____

Name of Patient/Minor (Please print clearly)

CANCELLATION/ SCHEDULING POLICY
PACK PHYSICAL THERAPY

(PLEASE READ CAREFULLY)

At **Pack Physical Therapy,** we want you to get the most out of your physical therapy every visit. We have accordingly recommended a certain amount of visits per week for your individual program. We strongly stress the importance of keeping all scheduled appointments for the success of your treatment.

Because we care about you and your progress, we need your help to keep our office running the best it can be. Please read the following in order to better help us, help you.

- **Heat:** In order to keep on schedule, please come 10 minutes prior to your appointment if you would like to have heat before your session, simply notify one of the techs you came early for heat.

- **Cancellation Notice:** We need your cooperation that if you are not able to keep one or more of your appointments you give us the **required twenty-four (24) hour notice**. Please contact our front office personnel in order to reschedule your missed appointment and we will do our best to have you seen that same week.

INITIAL _____

- **No-Show Notice:** Due to the increase in no show appointments, there is now a **$25.00** no show fee if you do not keep your appointment and did not give the office a **24 hour notice**. The only exception to the cancellation fee is in the case of an emergency. If repeat cancellations or No-Shows occur, we reserve the right to discontinue care and will inform your physician, attorney, case worker and or insurance company that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. ***Please be aware that you will be held responsible for this fee as your insurance <u>will not</u> cover it.**

INITIAL _____

In an instance of a cancellation without 24 hours notice or a no-show to a previously scheduled appointment, there is a <u>$25</u> (twenty-five dollar) fee.

- **Scheduling: As we run on 20 minute appointment times it is critical for you to be on time or early to your appointment.** Please communicate all scheduling needs to the front desk personnel even if you have already informed other staff members of your needed schedule changes, as miscommunication can occur. Should you fail to make appointments and still show up for treatment, or show up late to an appointment, please be advised that you may not be seen. However, with the therapist's approval, you may be seen at their convenience.

- **Doctor Visits:** Your doctor requests reports of your progress from your physical therapist. In order to comply with your doctor's request, please provide us at least one (1) week notice prior to when you are scheduled for your next doctor's visit.

Should you have any questions regarding this policy, please do not hesitate to let us know.

Thank you!

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Please Print

OFFICE POLICY FORMS
PACK PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT:
I do hereby consent to rehabilitation and related services at Pack Physical Therapy. In so doing, I understand there are no guarantees to the result of treatment. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

OFFICE POLICY ON PAYMENT:
It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made.

We have calculated your **ESTIMATED** patient portion for each visit to be $_____. This amount is based off of information gathered from your insurance company.

Deductible:_____ Ded Met:_____ Copay/Co-insurance:_____Visit limits:_____

The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement.

We have calculated your **AGREED** patient portion to be $_____ a visit towards your deductible up to $_____ then $_____ for each visit after the deductible is met.

CANCELLATION/NO SHOW POLICY:
Our office requires 24 hr notice for cancelling an appointment. If we do not receive notice of cancellation within 24 hrs a $25 cancellation/no show fee will be charged for that visit.

INSURANCE POLICY/ASSIGNMENT OF BENEFITS:
I request that payment of insurance benefits be made on my behalf to the provider for any services furnished to me. Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

ELECTRONIC SUBMISSION OF MEDICAL INFORMATION:
I understand if I want a copy of my medical information or financial account history I will have the opportunity to provide my verbal authorization to receive that information via email at the time of the request. Email is not considered secure by HIPAA guidelines. My signature on this form indicates my understanding that by opening such an email, I gave verbal authorization to receive, I have also given written authorization. I am aware of any risk this may pose to my PHI.

I have read the above and accept financial responsibility in full for this account.

X_____ **DATE:** _____
Patient/Guardian Signature

PATIENT CONSENT AUTHORIZATION
PACK PHYSICAL THERAPY

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care provided to me by **Pack Physical Therapy**. I understand that I am under the care of a licensed physical therapist and it is the responsibility of the staff to carry out the instructions of such physical therapists.

RELEASE OF INFORMATION:
By signing this form, you are granting consent to **Pack Physical Therapy** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION
THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:
1. Determining the extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and case manager, if it is applicable. If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program. Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your physical therapist any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in you condition, may be your *worst* enemy if performed too soon. Communication with your physical therapist will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

Research concerning the rehabilitation program and results may be conducted. Data will be used from the participant's evaluations and exercise program. No names will be used and all information is strictly confidential.

Physical therapy procedures are sometimes accompanied by post treatment soreness, disc injury aggravation, minor joint, ligament, tendon, or other soft tissue injury, minor burns to the skin while receiving moist heat as well as rare rib injury or fracture from thoracic spine adjustments. Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. These are not a normal and acceptable accompanying response to physical therapy.

Please advise your physical therapist if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms.

I understand that my progress and recovery also relies on the continuation of my therapy through my individual home exercise program given and explained to me by the staff of **Pack Physical Therapy.**

I understand that the staff at **Pack Physical Therapy** will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained. I understand that the practice of medicine is not an exact science and **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of any procedure.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below, related to the procedure described herein. I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by the physical therapists at this facility in the course of my treatment.

X _____
Print Patient's Name

X _____
Patient's Signature

_____
Date

Pack Physical Therapy
Statement of Privacy Notice

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

Pack Physical Therapy is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information

Disclosure of Your Health Care Information

Treatment: We may disclose your healthcare information to other healthcare professionals for the purpose of treatment, payment, emergency conditions and/or other healthcare operations.

Payment: We may use and disclose your medial information for payment purposes. We may share your health information with your physician for payment activities related to the care you received.

Health Care Operation: We may use and disclose your medical information for our healthcare operations. This might include internal quality control programs evaluating employee's performance, conducting training programs and getting accreditation, certificates, licenses and credentials.

Additional Uses and Disclosures: We may use and disclose your medical information for the following purposes.

Emergencies: to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Worker's Compensation: We may disclose your health information as necessary to comply with State Worker's Compensation Law's.

Public Health: As required by law, to public health authorities for purposes related to: preventing and controlling diseases, injury or disability, including child abuse or neglect, reporting domestic violence, to the FDA for purposes of reporting problems with products and medications, and reporting disease or infection exposure.

Judicial and Administrative: in response to a judicial or administrative order, subpoena, discovery request and other lawful process. Under limited circumstances, such as court order, warrant or grand jury subpoena with law enforcement officials. To law enforcement officials for the purposes of identifying and locating a suspect, fugitive, material witness or missing person, and/or other law enforcement purposes.

Specialized Government Functions: Subject to certain requirements, we may disclose your health information for military personnel and veterans, for national security and intelligence activities, for correctional institutions, and for government programs providing public benefits.

Deceased Persons; to help them carry out their duties, a coroner, medical examiner, funeral director or organ procurement organization.

Research: in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy or medical information.

Public Safety: to appropriate persons in order to prevent or lessen a serious or imminent threat to the health or safety of a particular person or to the general public.

Appointment Reminders: for the purpose of sending you appointment cards or leaving phone messages reminding you of your appointments

Your Health Information Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we amend any inaccurate or incomplete information in your records. You have a right to request restrictions on certain uses and disclosures of your health information you have a right to request restrictions on certain uses and disclosures of your health information. You have a right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You have a right to have your health information received or communicated in an alternative method or alternate location other than the usual method. You may request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider all requests on an individual basis, but are not legally required to accept them.

Concerns and Complaints
If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights by writing to the following address:

Pack Physical Therapy
Attn: Patient Information Privacy Officer
P.O. Box 3255
Dana Point, CA 92629

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way should you choose to file a complaint.