2255 Challenger Way #104
Santa Rosa, CA 95407
707.545.1419
www.santarosapt.com

PATIENT INFORMATION PLEASE PRINT CLEARLY

FIRST NAME:_____ MI:_____ LAST NAME:_____ DATE:_____

NICK NAME:_____ADDRESS:_____ APT:_____

CITY:_____ STATE:_____ ZIP:_____DATE OF BIRTH:_____ SEX:☐M /☐F

WORK PH:_____ HOME PH:_____ CELL: _____ EMAIL:_____

SOCIAL SECURITY NO:_____ APPT REMINDER? yes☐ no☐ :EMAIL☐TEXT☐NONE☐ AT&T VZN SPRINT ETC_____
(WE USE AN EMAIL SERVER SO WE NEED TO KNOW) CELL PHONE CARRIER

IF PATIENT IS A MINOR: MOTHER'S NAME/PHONE_____ FATHER'S NAME/PHONE_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE:_____

REFERRAL INFORMATION

WHO CAN WE THANK FOR REFERRING YOU TO SANTA ROSA PHYSICAL THERAPY?_____

REFERRING DOCTOR:_____ PHONE:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

DID THIS INJURY HAPPEN AT WORK? _____ HAVE YOU INFORMED YOUR EMPLOYER? _____ DATE OF INJURY_____
IF ACCIDENT- PLEASE COMPLETE THE FOLLOWING:

CLAIM TYPE (check one): ☐ WORKERS COMP ☐AUTO ☐ HOME ☐OTHER:_____ AUTO CANNOT BE THIRD PARTY

AUTO INS: _____ ADUSTER: _____ PH# _____ MED PAY ON POLICY? Y☐/ N☐

EMPLOYMENT INFORMATION

EMPLOYER:_____ PHONE:_____ OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURANCE INFORMATION (must present insurance card at the time of evaluation)

PRIMARY INS:_____ SECONDARY INS:_____ SUBSCRIBER NAME:_____

SS#:_____ SUBSCRIBER DOB:_____ RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT

CANCELLATION POLICY

24 Hour Cancellation Policy: Please provide 24-hour notice in order to reschedule or cancel your appointment. Note that your appointment time is reserved specifically for you; hence, late cancellations without valid reason will be charged $45.00.
_____(INITIAL HERE)

PRIVACY NOTICE

Privacy Policy: I have read the Health Information Privacy Policy _____(INITIAL HERE)

FINANCIAL RESPONSIBLITY

Billing: Co-pays and deductibles will be collected at the time of service. Santa Rosa Physical Therapy will bill your insurance. Please keep in mind that the co-pays collected at the time of service are an estimate of your cost based on benefits quoted by your insurance company and you may be responsible for unpaid or disallowed amounts. _____ (INITIAL HERE)

X_____
SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE SIGNED

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Name: _____ Height_____ Weight_____ Date:_____

Do you smoke? YES ☐ / NO ☐ If Yes how much per day? _____packs

How much alcohol do you usually drink? _____ per day /_____ per week

Date of injury, surgery or onset of current problems: _____

Please explain the type of pain you are experiencing: _____

Have you had any falls within the last 12 months? YES ☐ / NO ☐ Number of falls: _____

Please rate the intensity of your pain at best and at worst:

None ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Unbearable

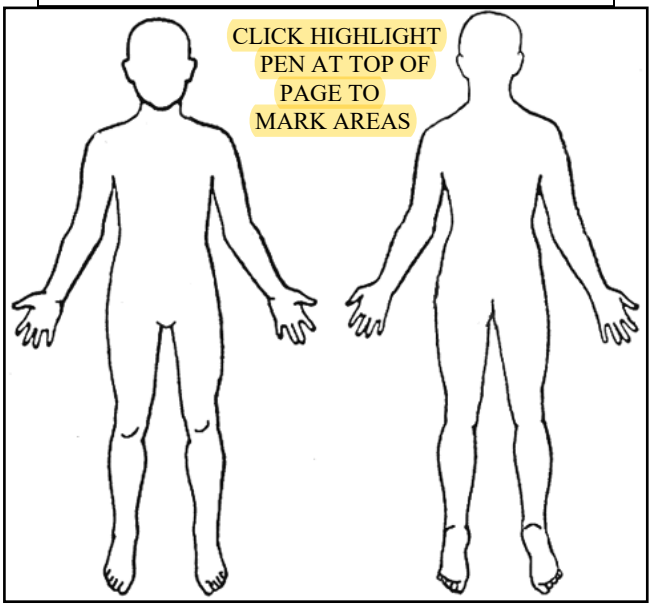
Sports/Recreational Activities: _____

Goals for therapy: _____

Please check if you have had any of the following conditions:

• Cancer	yes ☐	no ☐
• Diabetes	yes ☐	no ☐
• Hypertension	yes ☐	no ☐
• Angina or Chest Pain	yes ☐	no ☐
• Shortness of breath	yes ☐	no ☐
• Stroke	yes ☐	no ☐
• Asthma, hay fever	yes ☐	no ☐
• Hepatitis/jaundice	yes ☐	no ☐
• Cirrhosis/liver disease	yes ☐	no ☐
• Polio	yes ☐	no ☐
• Respiratory illness	yes ☐	no ☐
• Headaches	yes ☐	no ☐
• Anemia	yes ☐	no ☐
• Ulcers/stomach problems	yes ☐	no ☐
• Arthritis/gout	yes ☐	no ☐
• Seizure disorder	yes ☐	no ☐
• Unexplained weight loss/gain	yes ☐	no ☐
• HIV	yes ☐	no ☐

****Mark where you have pain or other symptoms****



Have you had x-rays, CT Scans, MRI or other diagnostics for this condition? _____

_____

Please list any previous surgeries or major injuries/illnesses: _____

_____

Please list current medications: _____

_____

Are you currently seeing any other health care practitioners for this condition? (Chiropractic, Massage, Acupuncture, etc.): _____

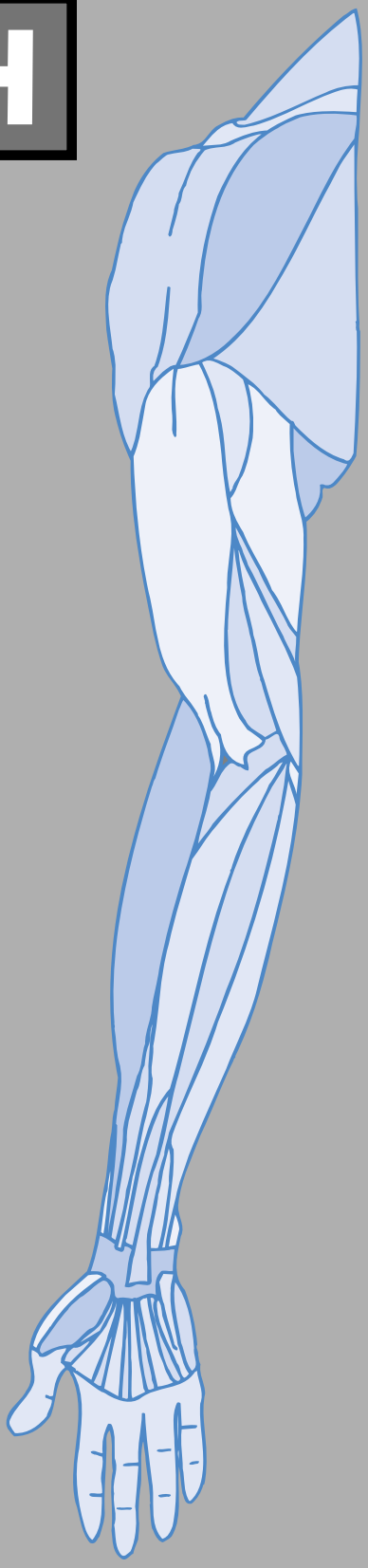
_____

Have you previously had treatment for this condition? _____

_____

Disabilities of the Arm, Shoulder and Hand

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Disabilities of the Arm, Shoulder and Hand

PATIENT NAME: _____

DATE: _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

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HIPPA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date:_____

If patient is a minor, Parent /Guardian name _____

X _____

Signature of patient, Guardian or authorized representative

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.
The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.
Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Santa Rosa Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.
It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy. I do hereby consent to such treatment as prescribed by my physical therapist or by any other physical therapist who may be treating me. I understand that only care appropriate to the setting will be provided and that the above company will, always, exercise good faith in this relationship. This consent is intended as a waiver of liability for such treatment with exception of acts of negligence. I agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Patient Name: _____ Date:_____

If patient is a minor, Parent /Guardian name _____

X

Signature of patient, Guardian or authorized representative

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Financial Responsibility

If you have provided your insurance information to our office, then we bill your insurance as a courtesy and will assist you to the best of our abilities with getting your claim paid.

However, you are financially responsible for any charges not covered by your insurance plan for services rendered to you.

WE ADVISE YOU CONTACT YOUR INSURANCE AS WELL, TO FIND OUT YOUR COVERAGE AND POSSIBLE OUT OF POCKET AMOUNTS THAT WILL BE OWED.

Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement. We have reviewed these benefits with you and you agree to pay your portion of your bill.

Insurance Company: _____

Deductible: _____

Estimated cost per visit: _____

Patient Name: _____ Date: _____

If patient is a minor, Parent /Guardian name _____

X _____

Signature of patient, Guardian or authorized representative

Effective Date: 02-10-17

Santa Rosa Physical Therapy
Notice of Privacy Practices for Protected Health Information
Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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

1. Purpose of this notice. In the course of doing business, Santa Rosa Physical Therapy, hereby referred to as the Covered Entity, gathers and retains protected health information about our patients. The Covered Entity respects the privacy of your protected health information and understands the importance of keeping this information confidential and secure. This Notice describes how the Covered Entity protects the confidentiality of your protected health information that we receive. The Covered Entity has implemented policies and procedures in accordance with federal and state confidentiality and privacy laws to protect your privacy. The Covered Entity is obligated to maintain the privacy and confidentiality of your protected health information. The Covered Entity is also obligated to provide you with notice of its legal obligations to maintain the privacy of your protected health information and to provide you with notice of its policies and procedures about privacy and confidentiality. These policies and procedures apply to past, present, and future patients of the Covered Entity and past, present, and future protected health information. The Covered Entity is required to abide by terms of the notice of privacy procedures currently in effect.

2. Definition of "Protected Health Information." "Protected Health Information" means any "individually identifiable health information that is transmitted by electronic media; (ii) maintained in Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media; or (iii) transmitted or maintained in any other form or medium." "Individually identifiable health information" is information that is a subset of "health information," including demographic information collected from an individual, and that: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Health information" means any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

3. Types of Uses and Disclosures of Protected Health Information Made. Federal law allows the Covered Entity to use and disclose your protected health information to provide health care services to you. It also allows the Covered Entity to bill and collect payments for the health care services provided to you. Finally, it allows the Covered Entity to use and disclose your protected health information as necessary in connection with the health care operations of the Covered Entity. For example, the Covered Entity may use your protected health information to verify your insurance benefits, or to receive authorization for physical therapy visits. The Covered Entity may disclose your protected health information to health plans or other responsible parties to receive payment for the services provided by your physical therapist. The Covered Entity might

also use your protected health information in connection with any grievance or appeal that you file if you are unhappy with the care that you have received. Certain governmental agencies may also request access to your protected health information to monitor the activities of certain providers, or even to monitor your health plan or insurance company. The Covered Entity may use your protected health information in connection with disease management programs. The Covered Entity may disclose your protected health information in connection with court orders and subpoenas.

Federal law allows the Covered Entity to use or disclose protected health information (i) for its own treatment, payment, or health care operations; (ii) to disclose protected health information for treatment activities of a health care provider; (iii) to disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information; or (iv) to disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is for (a) conducting quality assessment and improvement activities, including population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs, training of non-health care professionals, accreditation, certification, licensing or credentialing activities, health care fraud and abuse detection or compliance.

The Covered Entity is also allowed by law to use and disclose your protected health information without your authorization for the following purposes:

- When required by law
- For public health activities, such as reports about communicable diseases or work-related issues;
- In reports about child abuse, domestic violence, or neglect;
- For health oversight activities, such as reports to governmental agencies that are responsible for licensing physicians or other health care providers;
- In connection with court proceedings or proceedings before administrative agencies;
- For law enforcement purposes, such as responding to a court order or subpoena;
- In reports to coroners, medical examiners, or funeral directors;
- For tissue or organ donation;
- For research, with the approval of certain oversight entities; otherwise, use and disclosure of your protected health information for research requires your authorization;
- To avert a serious threat to the health or safety of a person or the public;
- For national security and intelligence activities, including the protection of the President;
- In connection with services provided under workers' compensation laws;

• For limited marketing purposes when related to your treatment.

The Covered Entity may disclose your protected health information to your family members who are involved in your care without either your consent or your authorization. However, you must be provided with an opportunity to object prior to disclosure.

All other uses and disclosures of your protected health information will be made by the Covered Entity only with your written authorization, which authorization you may revoke at any time.

The Covered Entity may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Covered Entity may contact you to raise funds for itself.

4. How We Protect Protected Health Information. The Covered Entity restricts access to your protected health information to those employees who need access to provide our services. We have established and maintain appropriate physical, electronic, and procedural safeguards to protect your protected health information against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a Privacy Officer that has overall responsibility for developing, training, and overseeing the implementation and enforcement of policies and procedures to safeguard your protected health information against inappropriate access, use, and disclosure, consistent with applicable state and federal law.

5. Authorizations. If an authorization is needed, the Covered Entity will provide you with an authorization form for you or your personal representative to complete. When you receive the form, please fill it out and return to our front desk staff, either in person, or by mailing to the following address:

Santa Rosa Physical Therapy
2255 Challenger Way Suite 104
Santa Rosa, CA 95407
Tel: 707-545-1419
Fax: 707-545-1435

6. Your Right to Access Protected Health Information. As a matter of federal and state law, you have the right to review and copy your protected health information received and retained by the Covered Entity, except in certain circumstances. If you want access to your protected health information, you must notify the Covered Entity in writing. The Covered Entity will respond to your request and provide a time and place, within normal business hours, for your inspection of the protected health information the Covered Entity has in its possession. If you request a copy of the information held by the Covered Entity, a copy can be provided. We reserve the right to charge a reasonable administrative fee for copying your protected health information, as allowed by applicable law.

7. Your right to amend protected health information. Federal and state law allows you the right to amend your protected health information held by the Covered Entity. A request to amend your protected health information must be submitted to the Covered Entity in writing, and the amendment must be no longer than 250 words in length. The Covered Entity will attach your amendment to the record(s) of your protected health information. Your amended protected health information will be made available for your review on request.

8. Your Right to Receive an Accounting of Disclosures. State and federal law provide you the right to request an accounting of all disclosures of your protected health information made by the Covered Entity that are not directly related to your treatment, payment for treatment, or the

Covered Entity's health care operations as outlined above. You may request an accounting in writing. The Covered Entity will provide this accounting to you within the period of time established by applicable regulations and in accordance with the policies and procedures established by the Covered Entity.

9. Your Right to Receive this Notice. You have the right to request and receive a copy of this Notice in written or electronic form. You may contact the Covered Entity for a copy, and one will be provided to you at no charge.

10. Your Right to Request Restriction on Disclosure of Protected Health Information. State and federal law permits you to request restrictions on the use and disclosure of your protected health information by the Covered Entity. The Covered Entity reserves the right to accept or reject your request for restriction. All requests must be made in writing. On receipt, the Covered Entity will review the request and notify you of its decision to either accept or reject the request. Even if the Covered Entity agrees to honor your request to restrict the Covered Entity's uses and disclosures of your protected health information, the Covered Entity may cease to honor that restriction without your consent, on notice to you. In that event, the Covered Entity will continue to honor the request for a restriction in connection with all protected health information, which the Covered Entity received or created prior to termination of the restriction. However, the Covered Entity will not be obligated to honor the restriction after it provides you with notice that it will cease to do so. If you agree to terminate, the Covered Entity may use and disclose all of your protected health information in it's possession in accordance with applicable law. All requests for restrictions that are agreed to by the Covered Entity will be made part of your protected health information and be made available for your review on proper request.

11. Your Right to Confidential Communications. You have the right to request that the Covered Entity provides your protected health information to you in a confidential manner. For example, you may request that the Covered Entity send your protected health information by alternate means or to an alternate address, such as by telephone to a different telephone number or to an office address rather than your home address. Also, you may, for example, request that your protected health information be sent in a sealed envelope rather than on a postcard.

12. Your Right to Complain. The Covered Entity is obligated to comply with the privacy practices set forth in this Notice. If you believe that the Covered Entity has violated this privacy policy, you have the right to file a complaint with the Covered Entity, the California Department of Managed Care, or the United States Department of Health and Human Service, Office of Civil Rights. The Covered Entity will not retaliate against you in any way for complaining.

13. Contacting the Covered Entity as to Your Rights. If you should have any questions regarding your rights or wish to make any of the above requests or complaints, you should direct your inquiries to:

Dave Townsend
Owner/Physical Therapist
Santa Rosa Physical Therapy
2255 Challenger Way, Suite 104
Santa Rosa, CA 95407
707-545-1419

14. Rights Reserved by the Covered Entity. The Covered Entity reserves all of the rights set forth above. The Covered Entity further reserves the right to amend or change the terms of this Notice at anytime and to make provisions of the new notice effective for all protected health information that we maintain. You may request updates to this Notice and such updates can also be found at our website, www.santarosapt.com.