Professional Physical Therapy
26471 Crown Valley Parkway, Suite 200
Mission Viejo, California 92691

Date _____

PATIENT REGISTRATION

Physician _____ Diagnosis _____

Last Name _____ First Name _____

Middle _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____

Home Phone _____ Cell Phone _____

PLEASE GIVE US YOUR E-MAIL IF YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

Email _____

Age _____ Date of Birth _____ Sex _____ Date of Onset _____

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO

IS THIS A RESULT OF A MOTOTR VEHICLE ACCIDENT? ☐ YES ☐ NO

ARE YOU CURRENTLY HAVING HOME HEALTH? ☐ YES ☐ NO

1. Treatment Authorization & Release of Information: I authorize treatment by Professional Physical Therapy. I authorize payment of medical benefits directly to Professional Physical Therapy for services rendered to me. I understand that I am solely responsible for all charges (unless this treatment is for an accepted workers compensation claim). I will make sure that my portions of all claims are paid promptly and all co-pays are paid at the time of service. I also authorize Professional Physical Therapy to furnish information to my insurance carriers and referring physicians concerning this treatment.

Patient or Guardian Signature _____ Date _____

2. Cancellation Policy & No Shows: I understand any cancellations that are not made 24 hours prior to my scheduled appointment time or no shows are subject to a $75 fee. This fee will be billed to my account.

Patient or Guardian Signature _____ Date _____

Professional Physical Therapy

26471 Crown Valley Parkway, Suite 200 Mission Viejo, CA 92691-6302

MEDCIAL HISTORY

Name: _____ Date: _____

Primary Care Doctor: _____ Phone: _____

Medical History- *Please circle all that apply to you*

Heart Diabetes Metal Implants Osteoporosis Smoking Pacemaker Kidney Bladder Control
Lung Currently Pregnant Seizures Gastro-Intestinal Cancer High Blood Pressure Anemia
Leg/Ankle Swelling

Other: _____

Height _____ Weight_____ Have you had a fall in the last year? Yes No (Circle one)

MEDICATIONS: Please list all medications with dosage/frequency that you are currently taking

_____

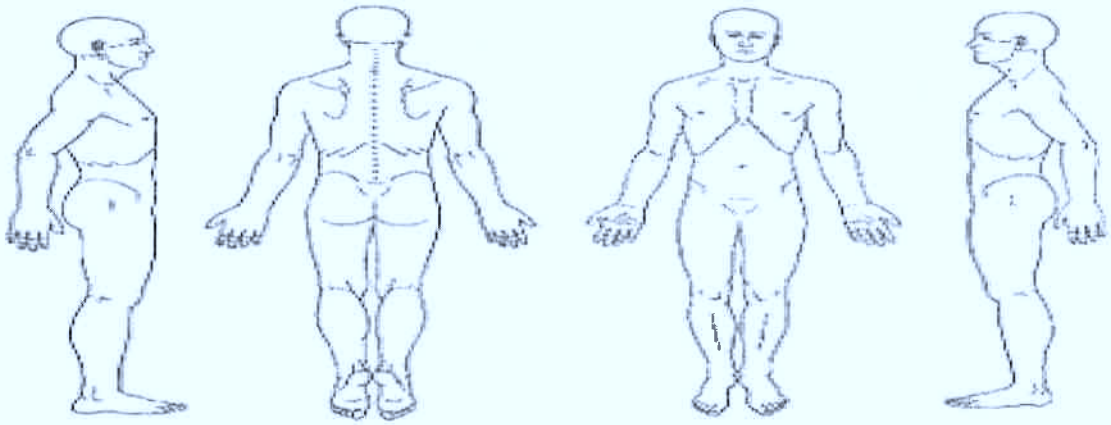
Allergies: (Please list any know allergies) _____

Using the diagram below, please circle your pain level: 0-No pain 10-Severe pain

(0 1 2 3 4 5 6 7 8 9 10)

Please write the letter by the body part that pertains to your symptoms:

S- sharp/stabbing, D-dull/aching, ST-stiffness, T- tingling/pins or needles, N-numbness/no sensation



EMERGENCY NOTIFCIATON:

NAME_____ RELATIONSHIP_____ PHONE#_____

NAME_____ RELATIONSHIP_____ PHONE#_____

To the best of my knowledge, all the information that I have provided is true and correct.

Signature: _____

Richards Physical Therapy, Inc.

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Richards Physical Therapy, Inc., may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment**: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse and business office staff. Richards Physical Therapy, Inc. will report to your prescribing physician and your insurance company.
2. **To obtain payment**: We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with the companies with similar commitment to the security of your health information.
3. **To conduct health care operation**: Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes or certification, licensing or credentialing activities.
4. **Communications**: Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or to contact us to schedule an appointment. These communications may include telephone, text or email reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law**: We may disclose your health information to public health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information, except for Initial Evaluations, Progress Notes, Plan of Care, Daily Notes and Re-Examinations .

You are entitled to receive a copy of this Notice of Privacy Practices.

I _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations as described in the Privacy Notice.

Signature:_____Date_____
(Parent/guardian if patient is a minor)

HOW IS YOUR BALANCE? NAME_____DATE_____

Falls Efficacy Scale

Take a bath or shower

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Reach into cabinets or closets

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Walk around the house

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of bed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Answer the door or telephone

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of a chair

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting dressed and undressed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Personal grooming (i.e. washing your face)

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting on and off of the toilet

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

QuickDASH - Initial Patient name:_____ Date:_____

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 of 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.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. 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
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code:

Professional Physical Therapy
Mission Viejo, CA

26471 Crown Valley Pkwy #200
(949)916-2601

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards and pre-approved insurance for which we are a contracted provider.
- **It is YOUR responsibility to know your own insurance benefits. This includes whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.**
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all our patients. We will ask to make a copy of your ID and insurance card(s) for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges usually higher co-payments and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- Workman's compensation injury/illness requires an authorization to treat from your employer. Should your employer fail to provide an authorization, we will work with your health insurance company for reimbursement as outlined below. Your insurance company might not cover the treatment if they consider the cause of the injury/illness to be workman's compensation related. You will be financially responsible.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payments for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

Professional Physical Therapy

: _____
Name

Confidential Channel Communication Request

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate with you regarding Physical Therapy/Occupational Therapy prescription information or respond to a message you left or questions you may have. We may communicate with you through and telephone, including leaving messages on your answering machine's/voice mail.

Please check all boxes that give Professional Physical Therapy Staff permission to use for your communication:

You may contact me by telephone Phone Number: _____ You may leave a message/voice mail Phone Number: _____
You may contact me by e-mail:

Please list any persons you would like to have access to your **billing, appointment**, or **health information,** such as your *spouse*, *caretaker* or other *family member*

.

Name/Phone Number	Relationship	Options
1.		Billing Information Appointment Information Medical/Health Information
2.		Billing Information Appointment Information Medical/Health Information
3		Billing Information Appointment Information Medical/Health Information
4		Billing Information Appointment Information Medical/Health Information

_____ _____

Signature of Patient/Responsible Party Date

Name of Patient/Responsible Party (Print) Relationship to Patient

_____ _____

Name: _____ Date: _____

Elder Abuse Suspicion Index (65 & OVER)

Instructions:

Questions 1-5 asked of patient. Question 6 asked by doctor within the last 12 months.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?

- ○ Yes
- ○ No
- ○ Did not answer

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?

- ○ Yes
- ○ No
- ○ Did not answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

- ○ Yes
- ○ No
- ○ Did not answer

4. Has anyone tried to force you to sign papers or to use your money against your will?

- ○ Yes
- ○ No
- ○ Did not answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

- ○ Yes
- ○ No
- ○ Did not answer

6. Doctor: Elder abuse may be associated with funding's such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

- ○ Yes
- ○ No
- ○ Not Sure

Name: _____ **Date:** _____

Depression Scale (18 YEARS & OVER)

Instructions:

Choose the best answer for have you have felt over the past week:

1. Are you basically satisfied with your life?	Yes	**No**
2. Have you dropped many of your activities and interests?	**Yes**	No
3. Do you feel that your life is empty?	**Yes**	No
4. Do you often get bored?	**Yes**	No
5. Are you in good spirits most of the time?	Yes	**No**
6. Are you afraid that something bad is going to happen to you?	**Yes**	No
7. Do you feel happy most of the time?	Yes	**No**
8. Do you often feel helpless?	**Yes**	No
9. Do you prefer to stay at home, rather than going out and doing new things?	**Yes**	No
10. Do you feel you have more problems with memory than most?	**Yes**	No
11. Do you think it is wonderful to be alive now?	Yes	**No**
12. Do you feel pretty worthless the way you are now?	**Yes**	No
13. Do you feel full of energy?	Yes	**No**
14. Do you feel that your situation is hopeless?	**Yes**	No
15. Do you think that most people are better off than you are?	**Yes**	No

Score Meaning:

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression

A score ≥ 10 points is almost always indicative of depression

A score > 5 points should warrant a follow-up comprehensive assessment