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WELCOME

Welcome to Orthopaedic and Sports Physical Therapy. Our physical therapists are California licensed and have considerable post-graduate education in orthopaedic and sports rehabilitation.

OFFICE HOURS

We schedule our first patients at 8:00 a.m. and our last at 5:00 p.m. We are open Monday through Friday.

APPOINTMENTS

When we schedule an appointment for you we have reserved that time for you, therefore, we ask that if you need to change or cancel an appointment that you give our office 24 hours notice. *Where 24 hours notice is not given, a \$12.00 rescheduling/no show fee may be charged and will be payable before the next appointment.*

FINANCIAL POLICIES

We will bill most insurance companies as a courtesy to our patients. We ask that deductibles and co-payments be paid at the time of service. We will call your insurance company for specific benefit information and inform you of such by your second visit. If you need special arrangements, please ask to speak with our Front Office Manager.

We are participating providers for: Medicare, Sutter Medical Group of the Redwoods, Blue Cross, Blue Shield, Cigna, Aetna, CCN, PHCS, and Foundation for Medical Care. **For balances that remain unpaid after 60 days, interest at the rate of 1.5% per month will be added.**

There are many different insurance company policies and physical therapy benefits vary. We encourage you to become familiar with your benefits. We will call your insurance company for benefits; however we will not guarantee that they will pay the exact amount stated. All unpaid charges by the insurance company will be the responsibility of the patient or guardian.

MEDICARE PATIENTS: You are required to see your physician every 30 days.

I have read and understand the above information.

Signature: _____ Date: _____



Attendance Policy and Agreement

We strive to provide our patients with the utmost professionalism and excellence in service. Our commitment to your well being and progress is something everyone in our clinic takes quite seriously.

Your adherence to recommended visits, treatments and exercises is a vital component of your progress. Therefore we request certain rules be followed in order to ensure optimum results.

It is expected that you keep all scheduled appointments.

A 24 hour notice is required for an appointment to be rescheduled. In such a case, please call our office and arrange for a make-up appointment, preferably within the same week.

In an instance of a cancellation without 24 hour notice or no-show to a scheduled appointment, a fee of \$12 will be due at your next appointment.

Attention Work Comp Patients: If you have two instances (in any combination) of a cancellation (without 24 hour notice) or no-show within a 30 day period, your future reserved appointments will be cancelled. You will then only be able to make same-day appointments. A notice will also be sent to your doctor and/or Case Manager. If you cancel or no-show to a same day appointment, you will be discharged from treatment due to non-compliance and your doctor and/or case manager will be notified.

Attention Private Insurance Patients: If you have three instances (in any combination) of a cancellation (without 24 hour notice) or no-show in a 30 day period, your future reserved appointments will be cancelled. You will then only be able to make same-day appointments. You will be discharged from treatment (due to non-compliance) if you cancel or no-show to a same day appointment.

We greatly appreciate you as a patient and strive to accomplish wonderful results and success for you.

By signing below, you certify that you have read and understand the above policy.

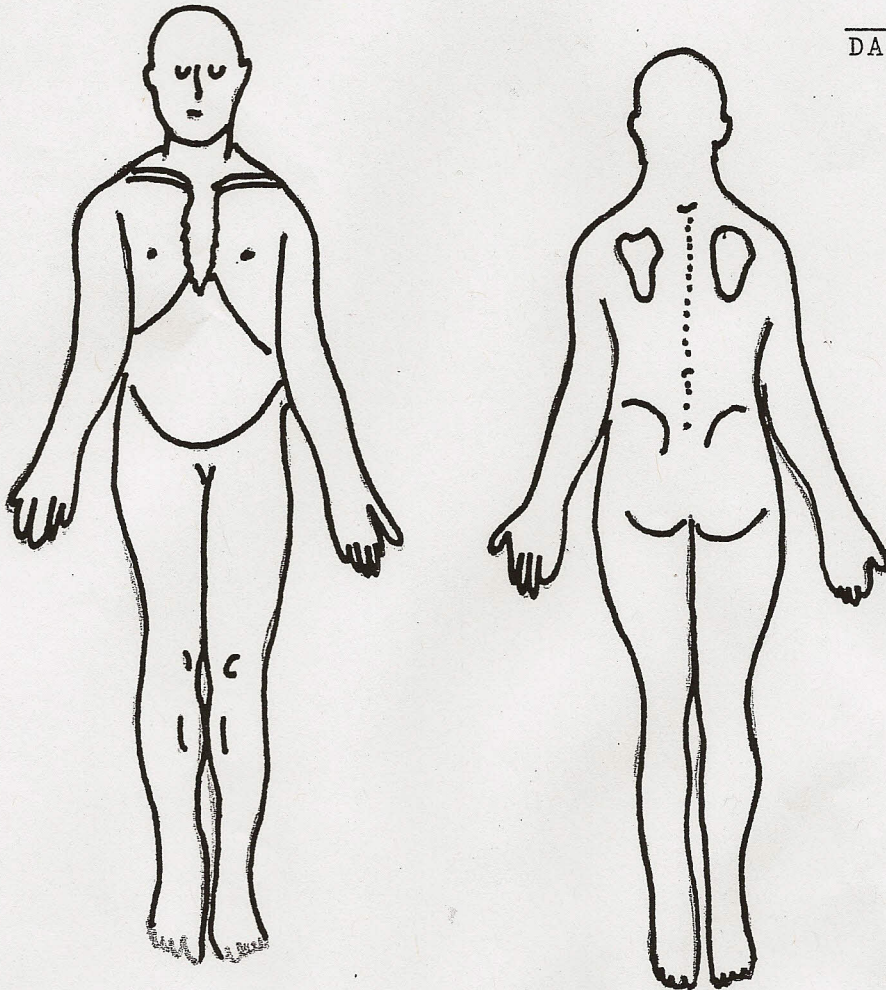
Signature: _____

Date: _____

Print Name: _____

PATIENT NAME _____

DATE _____



- 1) Please mark on the body diagram above, the areas where you feel your pain.
- 2) In the space below, please rate your pain on a scale of 1 - 10 (1 being very little pain, 10 being severe pain)

RATE YOUR PAIN 1-10

WITH ACTIVITY _____

AT REST _____

Medical History Intake Form

Patient Name: _____ Date: _____

DOB: _____ Age: _____

What is the reason for your visit today? _____

If you are female: Are you pregnant or trying to become pregnant? Yes No

Have you ever been told you have (please circle):

* Cancer	Yes	No	* Osteoporosis	Yes	No	* Hypoglycemia	Yes	No
* High blood pressure	Yes	No	* Heart Disease	Yes	No	* Angina or chest pain	Yes	No
* Shortness of breath	Yes	No	* Stroke	Yes	No	* Kidney disease/stones	Yes	No
* Urinary tract infection	Yes	No	* Allergies	Yes	No	* Asthma	Yes	No
* Rheumatic/scarlet fever	Yes	No	* Hepatitis/jaundice	Yes	No	* Cirrhosis/liver disease	Yes	No
* Polio	Yes	No	* Chronic bronchitis	Yes	No	* Pneumonia	Yes	No
* Emphysema	Yes	No	* Migraines	Yes	No	* Anemia	Yes	No
* Ulcers/stomach problems	Yes	No	* Depression	Yes	No	* Back/neck injuries	Yes	No
* Arthritis/gout	Yes	No	* Hemophilia	Yes	No	* Thyroid problems	Yes	No
* Tuberculosis	Yes	No	* Fibromyalgia	Yes	No	* Epilepsy	Yes	No

If you answered yes to any of the above, please explain: _____

Please list any medications you are taking (prescriptions or over the counter): _____

Do you have Diabetes? Yes No Type: _____ How is it controlled: _____

Do you smoke or chew tobacco? Yes No

Do you take steroids or anticoagulant medication? Yes No

Have you had any illnesses within the last 3 weeks? Yes No

Have you had any past surgeries? _____

Do you have (please circle):

Pacemaker Transplanted organ Joint replacement Metal implants

Have you had any test for this problem (please circle): X-RAY MRI CT LAB

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____ hereby consent to the therapeutic procedures outlined below, to be performed by Orthopaedic and Sports Physical Therapy and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions &/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat,ice, E-stim and ultrasound; and special procedures such as taping, neuromuscular E-stim and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Orthopaedic and Sports Physical Therapy or from any other source.

I certify that I have read and understand the above consent statements:

Patient's Signature: _____ **Date:** _____

Physical Therapist's Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Orthopaedic and Sports Physical Therapy. I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, Auto), then I am financially responsible and agree to pay for all charges related to services provided to the patient at the medical group.

Although I have requested Orthopaedic and Sports Physical Therapy to bill my insurance company on my behalf, I clearly understand that I am responsible directly to Orthopaedic and Sports Physical Therapy for payment on my account regardless of the status of my insurance claim.

Patient's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name: _____ **Date:** _____

Patient's Signature: _____

Parent or Authorized Representative (if applicable)

ORTHOPAEDIC AND SPORTS PHYSICAL THERAPY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SUMMARY OF NOTICE OF PRIVATE PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information. We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization.

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members to close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product deficits or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights.

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.