Central Santa Rosa
795 Farmers Lane, Suite 10
Santa Rosa, California 95405
Main: 707.571.7615
Fax: 707.571.8601

East Santa Rosa & Oakmont
6574 Oakmont Drive, Suite D
Santa Rosa, California 95409
Main: 707.539.5256
Fax: 707.539.7914

Welcome to Orthopaedic and Sports 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.

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.

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. 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 90 days.

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.

Patient Signature	Date

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Patient Information

Patient Name		
Address		
City	State	Zip
Home#	Cell#	Work#
SSN	Date of Birth	Age
Employer	Occupation	Family Dr.
Is problem to an auto or workplace accident?		
Person responsible for charges (if other than yourself)		
Relation	SSN	
Address		
City	State	Zip
Date of Birth	Employer	
Home#	Cell#	Work#

Insurance Information

Policy Holder (if other than yourself)		Date of Birth
Address		
City	State	Zip
Phone#	SSN	Employer

Emergency Contacts (one that does not reside with you)

Name	Relationship	Phone#
Name	Relationship	Phone#

Email

How did you hear about OPST? (please check all that apply)

( ) Physician Referral ( ) Friend ( ) Yellow Pages ( ) Advertisement ( ) Online

( ) Other _____

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Orthopaedic and Sports Physical Therapy

Health Insurance Portability and Accountability Act Summary of Notice of Privacy 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.

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 Signature	
Parent or Authorized Representative (if applicable)	

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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 and/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 Signature	Date
Physical Therapist Signature	Date

Financial Responsibility Policy

I understand that Orthopaedic and Sports Physical Therapy is billing my insurance as a courtesy, and I hereby assign all physical therapy benefits directly to Orthopaedic and Sports Physical Therapy. I understand that most insurance companies, (including Medicare), pay only a certain percentage of patient services depending on the policy, and should they deny my claim or any portion due, and that I am financially responsible and agree to pay for all charges related to services provided to me at Orthopaedic and Sports Physical Therapy, regardless of the status of my insurance claim.

I agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay Orthopaedic and Sports Physical Therapy promptly upon receipt of the statement. I understand that interest at a rate of 1.5% per month may be added to unpaid balances due for coinsurance, co-payment, or deductible. In exceptional circumstances, an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within ten (10) days of my initial visit to the office.

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to Orthopaedic and Sports Physical Therapy for any services furnished to me by Orthopaedic and Sports Physical Therapy.

I understand my signature authorizes the release of my medical information to the insurance company, indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims. This information will only be disclosed to the insurance company once it has been requested and deemed necessary information needed to determine these benefits payable to related services by the insurance company.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. This authorization will remain valid until rescinded in writing.

I have read the above and full understand the terms thereof.

This is a teaching facility; you may be treated by a physical therapy intern, under the supervision of a licensed physical therapist.

Patient Signature	Date

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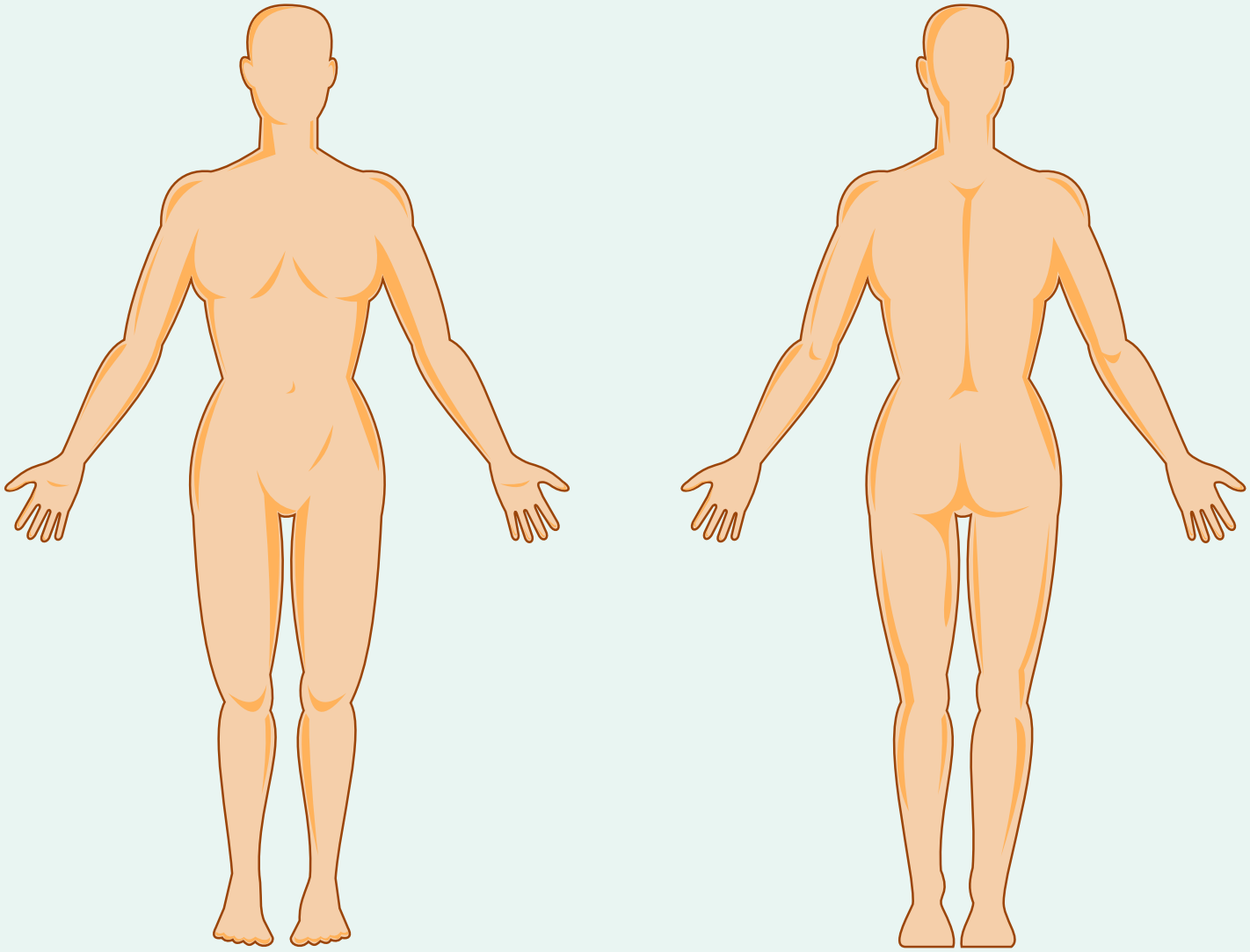
Patient Name	Date

Please mark on the body diagram below the areas where you feel your pain.



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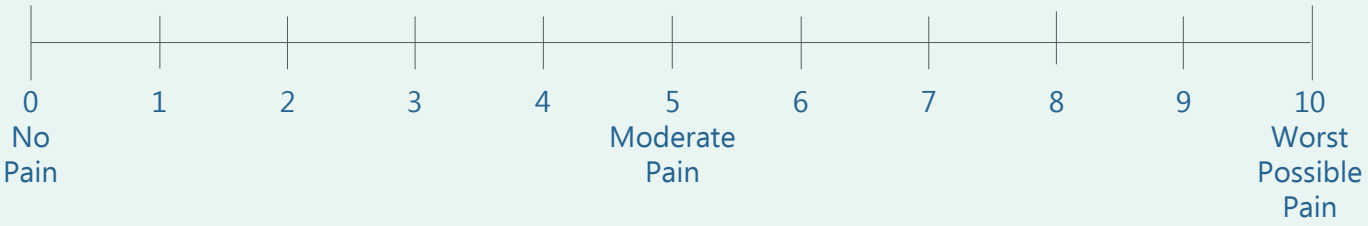
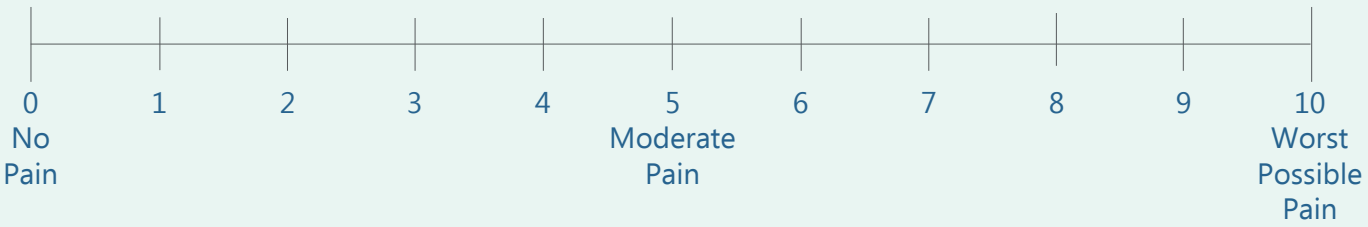
Describe how your daily activities are affected by your pain. (List specific activities at work or home that you are not able to perform without pain).

Please mark on the scle below your level of pain while At Rest.



Please mark on the scle below your level of pain During Activity.



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Medical History Intake Form

Patient Name	Date
Date of Birth	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 Problem	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 and 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 sugeries?	
Do you have: ( ) Pacemaker ( ) Transplanted Organ ( ) Joint Replacement ( ) Metal Implants	
Have you had any test for this problem? (please check) ( ) X-Ray ( ) MRI ( ) CT ( ) Lab	