POTENTIAL
PHYSICAL THERAPY

Name: _____

Street Address: _____

_____ AGE: ____ Birthdate _____ M F
City State Zip (mm/dd/yyyy) (circle one)

Home Phone: ( )_____ Work Phone ( )_____ Cell Phone: ( )_____

May we contact you by Email? Yes ____ No ____ Email address _____

May we text your cell phone? Yes_____ No _____ Employer/job title: _____

Emergency Contact: _____ Phone # ( )_____ Relationship: _____

Is this related to an auto accident? ____Yes ____No

Family Physician: _____ Referred by: _____

_____

****

LATE POLICY:

*In order to respect our patient's time, we make every attempt to start and end our sessions promptly as scheduled. If **you** are late, you are responsible for the full fee for the session.*

Signed _____

CANCELLATION OR NO SHOW POLICY:

*I understand that if I am unable to cancel my scheduled appointment 24 hours in advance, or "No Show," I will be charged a **$65.00 fee.***

Signed _____

I understand that Karen and Steven Anderson PT through Potential Physical Therapy are not a contracted member of my insurance company. I understand that payment for services is due at the time of visit and that I will receive a receipt with the appropriate codes that I can submit to my insurance company for out of network benefits.

Signed _____

POTENTIAL
PHYSICAL THERAPY

What is Physical Therapy?

Physical therapy is a patient care medical service that is provided in order 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 various interventions.

Physical therapy treatment may include any one or a combination of manual treatments, modalities (modalities that use the physical and chemical properties of light, heat and electricity) and therapeutic exercises with or without equipment as deemed appropriate by the physical therapist.

Potential Benefits:

The primary goals and benefits of physical therapy are to restore and maintain normal function and movement. Common benefits associated with physical therapy include, but are not limited to, improvement in joint range of motion, muscle strength and flexibility, cardiovascular endurance, physical performance, body mechanics, decreased pain levels, reduction of future injury risk and prevention of various diseases.

You should gain a greater knowledge about managing your condition and the resources available to you. Your therapist will share their opinion regarding potential results of physical therapy and discuss your treatment options.

Potential Risks:

As with any medical procedure, there are risks. Response to physical therapy treatment varies from person to person. It is not possible to accurately predict your response to a specific treatment, modality, procedure or treatment.

Potential Physical Therapy cannot promise or guarantee that the treatment will resolve or improve your condition.

You have the right to decline any part of your treatment at any time, should you have any concerns.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also ask questions at any time and may discuss with your therapist what the potential risks and benefits of a specific treatment might be.

There is the possibility that physical therapy treatment may result in aggravation of existing symptoms and an increase in your current level of pain or discomfort. This discomfort is usually temporary and should not exceed 24-48 hours. If discomfort does persist, you should contact your physical therapist.

By signing below, I acknowledge that I have read and understood this consent form and agree to proceed with physical therapy evaluation and treatment. I understand that this consent will cover the entire course of treatment for my present condition and for any future condition for which I shall seek treatment from Potential Physical Therapy.

Patient's Name _____ Patient Signature _____ date _____

(If patient is a minor, parent or legal guardian must sign this consent)

NOTICE OF PATIENT INFORMATION PRACTICES

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

POTENTIAL PHYSICAL THERAPY'S LEGAL DUTY

Potential Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Potential Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Potential Physical Therapy** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Potential Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies. We also provide information when required by law.

In any other situation, **Potential Physical Therapy** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Potential Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL 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 correct any inaccurate or incomplete information in your records. You also have the 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 may also 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. **Potential Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Potential Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Potential Physical Therapy** health information practices or if you have a complaint, please contact:

Potential Physical Therapy
1291 E. Hillsdale Blvd. Suite 309
Foster City, CA 94404

Telephone: 650 334 6071
Email: info@potentialphysicaltherapy.com

HIPAA PRIVACY NOTICE AND PATIENT INFORMATION CONSENT FORM

I have read and fully understand *Potential Physical Therapy* Notice of Information Practices. I understand that *Potential Physical Therapy* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that *Potential Physical Therapy* will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in *Potential Physical Therapy* Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name _____

Signed _____ Date _____

****

Please sign the authorization below if you would like to share your medical information with a family member, friend or medical provider other than the referring physician.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name _____

Signed _____ Date _____

HEALTH QUESTIONNAIRE

Name_____ Age_____ Date_____

Occupation_____Are you working? YES / NO Hours/week_____

1. Describe your symptoms _____

_____

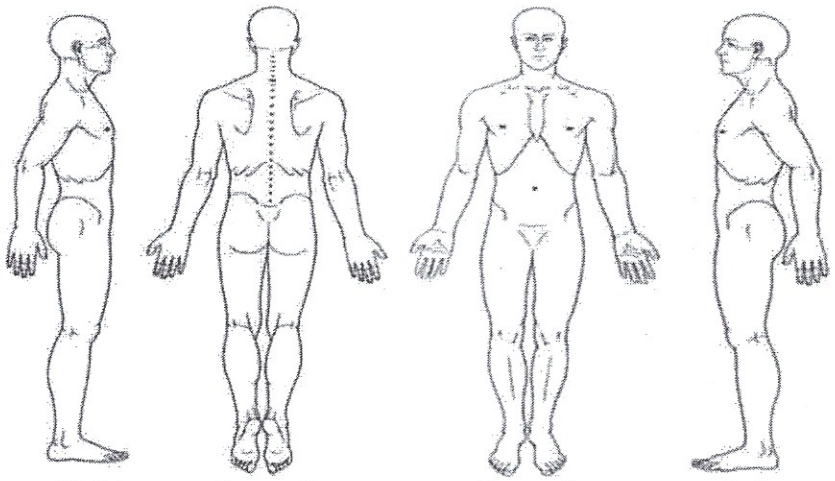
When did your symptoms start? _____

Did your symptoms start: gradually____ suddenly_____ chronic _____ If chronic, how long? _____

Can you remember an incident that caused your symptoms (Please describe)

_____

2. **Draw on the figures below where you have pain or other symptoms. Refer to the numbers below the figures to rate your symptoms. If pain varies, please give a range (such as 3-5). If there is more than one area, please rate the pain for <u>each area</u>.**



0 1 2 3 4 5 6 7 8 9 10

None **Difficult, but can function with medication** **Unbearable requires hospitalization**

What is most painful area:_____ Pain at present_____ Best_____ Worst_____

Next most painful area:_____ Pain at present_____ Best_____ Worst_____

Next most painful area:_____ Pain at present_____ Best_____ Worst_____

3. How often do you experience your symptoms?

a. constantly (76-100% of the day)
b. frequently (51-75% of the day)
c. occasionally (26-50% of the day)
d. intermittently (0-25% of the day)

4. Describe the nature of your symptoms

a. sharp
b. dull ache
c. numb
d. shooting
e. burning
f. tingling

5. How are your symptoms changing?

a. getting better
b. not changing
c. getting worse

6. In general your overall health is...

a. excellent
b. very good
c. good
d. fair
e. poor

7. Who have you seen for your symptoms? a. No one b. medical doctor c. physical therapist d. chiropractor e. Other _____

What treatment did you receive and when (include surgery)? _____

_____

8. Have you had: X-rays date:_____ CT scan date:_____ MRI date:_____ Other date:_____

9. Have you had similar symptoms in the past? YES / NO If you received treatment for similar symptoms who did you see? a. This office b. medical doctor c. chiropractor d. physical therapist e. other

10. How much has pain interfered with your work/housework/daily life?
a. not at all b. a little bit c. moderately d. quite a bit e. extremely

During the past 4 weeks, how much have your symptoms interfered with social activities?
a. not at all b. a little bit c. moderately d. quite a bit e. extremely

Describe physical limitations due to this injury_____

_____

11. Do your symptoms change during the day? YES / NO How?_____

12. Do your symptoms wake you up at night? YES / NO How often?_____

How many hours do you sleep at night? _____ In what position do you sleep?_____

13. What aggravates your symptoms?_____

_____

14. How do you ease your symptoms? (for example, ice, meds, heat, exercise, positions, other) _____

_____

15. How long can you sit_____ stand_____ walk_____ before your pain increases?

How long can you sit_____ stand_____ walk_____ before you have to stop?

16. **Please list ANY other PAST medical conditions or accidents (surgeries, illness, trauma) whether or not you feel they are related to your present condition:**

Please list ANY other PRESENT medical conditions:_____

17. **Do you get lightheaded or dizzy when you look up or turn your head? YES / NO**

18. Please list all current medications including over-the-counter and herbals:

19. Prior to this injury, did you have a routine exercise program? YES / NO What was it?_____

_____

Has this injury changed your exercise? Yes No How?_____

20. When did you last have a complete physical from your doctor? _____

Do you experience any of the following symptoms or conditions?

Do you have any metal implants, screws, or pins?	YES_____	NO_____
Have you had a joint replacement?	YES_____	NO_____
Do you have a pacemaker?	YES_____	NO_____
Have you ever had cancer?	YES_____	NO_____
Are you pregnant?	YES_____	NO_____
Do you have heart disease?	YES_____	NO_____
Are you being treated for high blood pressure?	YES_____	NO_____
Do you have diabetes?	YES_____	NO_____
Do you have osteoporosis?	YES_____	NO_____
Do you smoke?	YES_____	NO_____
Do you have increased sweating or night sweats?	YES_____	NO_____
Headaches?	YES_____	NO_____
Weakness?	YES_____	NO_____
Difficulty Swallowing?	YES_____	NO_____
Heartburn/Indigestion?	YES_____	NO_____
Specific food intolerance? Please Specify _____	YES_____	NO_____
Changes in bowel pattern (texture, color, frequency)?	YES_____	NO_____
Difficulty urinating (starting, stopping)?	YES_____	NO_____
Urine frequency changes?	YES_____	NO_____
Difficulty breathing/shortness of breath?	YES_____	NO_____
Difficulty breathing when lying down?	YES_____	NO_____
Wheezing?	YES_____	NO_____
Do you have swelling in feet or hands?	YES_____	NO_____
Do you have clicking noises in jaw or ear?	YES_____	NO_____
Do you have dizziness/lightheadedness?	YES_____	NO_____
Do you have any problems with balance?	YES_____	NO_____
Do you have a history of falls?	YES_____	NO_____
Do you have pain at night?	YES_____	NO_____

What are your goals for treatment? What would you like to do that you are unable to do now because of this condition?

Patient signature _____ Date_____