thrive PHYSICAL THERAPY

8740 Warner Avenue
Fountain Valley, CA 92708
Tel: 714. 435. 9909
Fax: 714. 475. 1939

PATIENT INTAKE FORM

IF THIS CONDITION IS A RESULT OF A WORK INJURY, PLEASE DO NOT COMPLETE THIS FORM. PLEASE NOTIFY OUR FRONT OFFICE ASSISTANT.

PATIENT'S PERSONAL INFORMATION

Full Name: _____ DOB: _____ Age: _____

Birth Sex: Male / Female **Handedness:** Right / Left / Ambidextrous

Marital Status: Single / Married / Divorced / Widowed

Are you currently working? Yes / No Occupation: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone ( ) _____ Cell Phone ( ) _____ Driver's License #: _____

E-mail: _____ Social Security # _____

Reason for today's visit: _____

_____

PATIENT INJURY / REFERRAL INFORMATION

Date of injury/onset/change of status: _____ Treatment side: Left / Right / Both / N/A

Related Cause: Auto Accident / Fall / Employment Injury / Sports Injury / Surgery / Other: _____

Date of Surgery: _____ Type of Surgery: _____

Referring Physician: _____ Return to Dr. Date: _____

Have you had previous physical therapy, occupational therapy, or speech therapy this calendar year? Yes / No

Have you had home therapy? If so, when? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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

Signature: _____ Date: _____ Employee Initials: _____

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:_____ ☐ **TRANSLATOR REQUIRED**

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PATIENT CONSENT AND RELEASE FORM

PATIENT CONSENT FOR EVALUATION & TREATMENT

_____ I understand that the physical therapist will explain to me any potential risks, benefits, and alternatives to treatment. I understand that there are no guarantees regarding cure or improvement in my condition. I understand that my physical therapist will outline and discuss the goals of physical therapy for my condition and review treatment options with me.

I do hereby consent to such treatment by an appropriately credentialed Thrive Physical Therapy clinical staff member as may be dictated by prudent medical practice by my illness, injury, or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

RELEASE OF INFORMATION

_____ I understand my physician will receive information concerning my condition while I am treated at Thrive Physical Therapy. I understand the information may be verbal or in writing. I authorize Thrive Physical Therapy to release any necessary information to my insurance carrier and authorize payments for any physical therapy benefits available under my insurance plan.

FINANCIAL AND INSURANCE RESPONSIBILITIES

_____ I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor and Industries claims. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. If for any reason my insurance should deny payment, I understand that I am liable for all charges incurred for services rendered. I agree to pay the balance owed within 30 days of receiving a bill. I understand that failure to pay any amounts owed may result in my account being placed in collections. I understand the parent accompanying a minor for treatment will be responsible for payment.

_____ I understand I can only obtain therapy services one at a time. I understand it is my responsibility to notify my insurance company and Thrive Therapy if I am obtaining therapy services elsewhere. Failure to do so, may result in my account being placed in collections and/or canceled appointments.

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

_____ I acknowledge that I have been notified that Thrive Physical Therapy routinely attempts to contact patients during normal business hours and is occasionally unable to reach patients directly during that time. On these occasions our office leaves messages on answering machines or voice mail at numbers provided by our patients. Information that we may possibly disclose on your home, work or cell phone could include, but is not limited to, scheduling concerns or appointment information.

NO SHOWS / CANCELLATIONS

_____ I acknowledge that I will be charged a $50.00 fee the second time that I do not show up to my appointment without prior 24-HR notice. This fee needs to be paid before I am able to be seen by Thrive Physical Therapy. I also understand that if I no show or cancel more than two times that Thrive Therapy has the right to discontinue my treatment at their facility. After two failed appointments without notification, your remaining appointments will be taken off the schedule until you notify us by telephone or in person.

TIMELINESS

_____ I acknowledge that Thrive Physical Therapy reserves the right to reschedule my appointment if I arrive more than 10 minutes past my appointment time for my initial visit and 15 minutes for follow-up treatments.

I have acknowledged that I have read and understand the information above.

_____ _____ _____

Patient's Name (Print) Patient/Representative Signature Date

_____ _____

Printed Name Relationship (parent, legal guardian, etc.)

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NO SHOW / 24 HOUR CANCELLATION POLICY

Thrive Physical Therapy strives to provide the highest quality of care with your collaboration. Therefore, we reserve one hour time slots for each patient to ensure continuity of care and to minimize wait time. Advanced time slots allow us to fulfill patient's scheduling needs and keep the clinic operating at the most efficient level. Complete attendance to your physical therapy sessions is vital to your recovery.

No show, last minute cancellations, and cancellation less than 24 hours is an inconvenience and displays a lack of respect to the clinic, your physical therapist, and your fellow patients. We must ask you to comply with the following policy to ensure your best care.

1. **Please provide our office 24-hour notice of cancellation to change a scheduled appointment. Failure to do so will result in a $50.00 service charge.** The patient is responsible for this fee and cannot be billed through insurance or third party payers.

2. If you are **10 minutes** late to your appointment and fail to notify us, treatment may be canceled, and a fee charged.

3. Failure to show up to a scheduled appointment without notification ("NO SHOW") will result in a $50 fee charged and you may not be able to reschedule for that week.

4. 2 consecutive NO SHOW's will result in a fee charged and cancellation of all future appointments.

5. Repeated NO SHOW's and failure to comply with this policy will result in placing you on same-day scheduling policy, which will not allow you to schedule appointments in advance.

6. All cancellations and NO SHOW's are documented in your medical record and appropriately reported to your physician, insurance, and third party payers.

Thank you for your cooperation. Thrive Physical Therapy wishes you the best in your recovery!
I have read, understand, and agree to the policy above:

Print name: _____

Signature of Patient: _____

Date: _____

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PATIENT MEDICAL INFORMATION FORM

Name: _____ **Date:** _____

DOB: _____ **Gender:** Male / Female **Height:** _____ **Weight:** _____

Have you ever experienced or been told you have any of the following conditions?

Please check all that applies and explain below.

☐ Alzheimer's	☐ History of Cancer
☐ Cardiovascular Disease	☐ Huntington's
☐ Cauda Equina Syndrome	☐ Immunosuppression
☐ Cerebal Vascular Accident / Stroke	☐ Lupus
☐ Current Infection	☐ Muscular Dystrophy
☐ Diabetes Mellitus Type 1	☐ Obesity
☐ Diabetes Mellitus Type 2	☐ Osteoarthritis
☐ Fibromyalgia	☐ Parkinson's
☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Fracture Or Suspected Fracture	☐ Traumatic Brain Injury
☐ High Blood Pressure	☐ Allergies

Please explain (if applicable):

_____

Please list any other conditions not listed above:

_____

Are you currently taking any medications?

- ☐ Prescription
- ☐ Over The Counter
- ☐ Herbals
- ☐ Vitamin/Mineral/Dietary Supplements
- ☐ Other_____
- ☐ Not currently taking any medications

Please list (if applicable):

_____
_____
_____
_____
_____
_____

Do you have any previous surgeries or injuries?

- ☐ Surgery
- ☐ Injury
- ☐ Work Related
- ☐ Auto Accident
- ☐ Other_____

Please list (if applicable):

_____
_____
_____
_____
_____
_____

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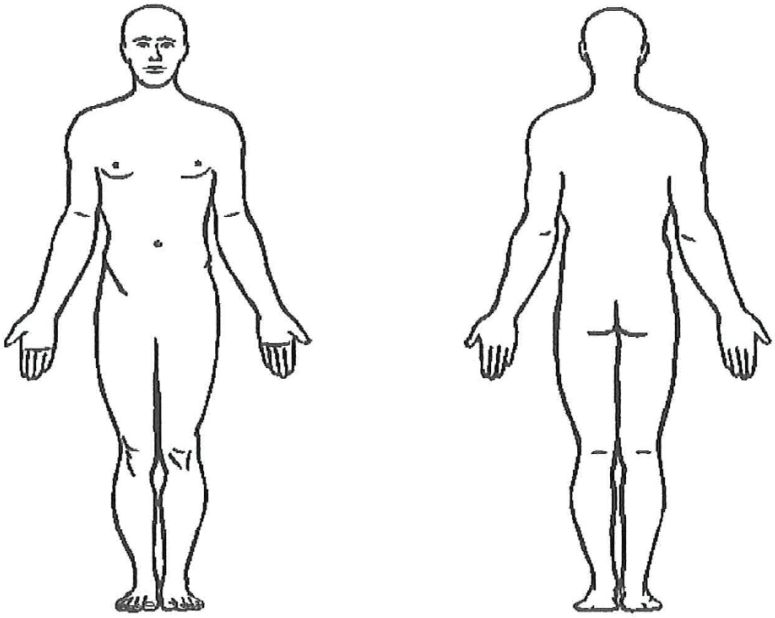
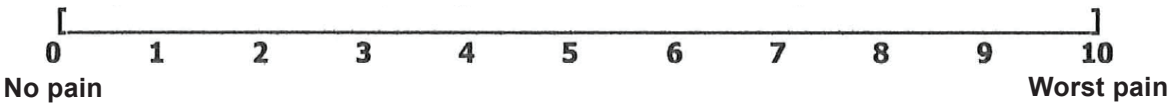
PAIN ASSESSMENT

Name: _____ Date: _____

Please indicate where your pain is located by circling the affected region below:



Please indicate your current level of pain: (please circle a number below)



Short Form McGill Pain Questionnaire

Instructions: Read the following descriptions of pain and mark the number which indicates the level of pain you feel in each category according to the following scale:

	1 = None	2 = Mild	3 = Moderate	4 = Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				
Total Score:				

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APPOINTMENT:_____

HIPAA NOTICE OF PRIVACY PRACTICE

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.

USES AND DISCLOSURES

Treatment includes the utilization and disclosure of your protected health information, which may include other health care professionals who have referred you for services or are involved in your care, to provide, coordinate, and manage your health care.

Payment includes the utilization and disclosure of your protected health information to your insurance company to obtain payment for your health care services

Health Care Operations include the utilization and disclosure of your protected health information for the purpose of routine health care operations.

Required by Law includes disclosure of your protected health information when required to do so by Federal, State, or local law.

Legal Proceedings includes the disclosure of your protected health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

Public Health Reporting includes the disclosure of your protected health information to public health agencies as required by law.

Workers' Compensation includes the disclosure of your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Appointment Reminders includes the utilization and disclosure of your protected health information by our staff to contact you as a reminder that you have an appointment.

Your authorization is required before your protected health information may be used or disclosed by us for other purposes.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to inspect and copy your protected health information
- the right to request restrictions on how your protected health information is used
- the right to request to receive confidential communications from us by alternative means or at an alternative location
- the right to request an amendment be made to your protected health information
- the right to request an accounting of certain disclosures we have made, if any, of your protected health information
- the right to receive a copy of this notice

OUR DUTY TO PROTECT YOUR PRIVACY

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your protected health information. These rules require us to provide you with this document, our Notice of Privacy Practices.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you may contact:

Address: 8740 Warner Avenue
Fountain Valley, CA 92708
Phone Number: (714) 435-9909

If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Effective Date: April 14, 2003
Revised Date: May 2, 2012

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HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

The Health Insurance Portability and Accountability Act require that health care providers provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the notice.

You have the right to review our notice before signing this acknowledgment, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information.

You may refuse to sign this acknowledgment form.

By signing below, I acknowledge that I have been provided a copy of the HIPAA Notice of Privacy Practices.

_____	_____	_____
Patient's Name (Print)	Patient/Representative Signature	Date
_____	_____	
Printed Name (if signed on behalf of the patient)	Relationship (parent, legal guardian, etc.)	

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify):_____

_____	_____
Therapist / Staff signature	Date