

**CAMPBELL'S PREMIER PHYSICAL THERAPY**

**163 E HAMILTON AVE  
CAMPBELL, CA 95008  
P 408-866-5567 F 408-866-1317**

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_\_

GENDER:  MALE  FEMALE

PHONE #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ SECONDARY PHONE #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMERGENCY CONTACT NUMBER: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**PLEASE GIVE YOUR ID AND INSURANCE CARD(S) TO THE RECEPTIONIST**

INSURANCE COMPANY: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_ GROUP: \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP: \_\_\_\_\_

**IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICYHOLDER**

POLICYHOLDER'S NAME: \_\_\_\_\_ POLICYHOLDER'S DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

POLICYHOLDER'S PHONE #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

STREET ADDRESS OF POLICYHOLDER: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT INFORMATION:**

NAME: \_\_\_\_\_ PHONE: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

I/WE UNDERSTAND THAT I/WE ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I/WE AGREE TO ACCEPT TOTAL RESPONSIBILITY FOR ALL DAMAGES AND AGREE TO PAY AT THE TIME SERVICES ARE RENDERED, OR NOT LATER THAN 30 DAYS OF SUCH SERVICES. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COST OF COLLECTION, INCLUDING ATTORNEY FEES.

X \_\_\_\_\_

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF, AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE PHYSICIAN ON ANY UNPAID CLAIM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

X \_\_\_\_\_

## MEDICAL BENEFITS & POLICIES

### Medical Necessity

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Physical Therapy visits will be provided according to medical necessity.

Therefore, it is our office policy that a doctor's referral is necessary to be seen at Campbell's Premier Physical Therapy.

### Physical Therapy Benefits

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Please ask us if you have any questions about your benefits or contact your insurance carrier.

**We will bill your insurance for you but in case of non-payment by your carrier, it is your responsibility to pay for the services.**

**NOTE:** If you are not using an insurance and will be SELF PAY, or you have not yet met the deductible amount that your insurance requires from you, we will be collecting payments at every visit that will be applied toward your insurance deductible.

### 24 Hour Cancellation and "No Show" Policies

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If it is necessary to cancel or reschedule your appointment, we require a 24 hour advance notice. Appointment times are in high demand and this will allow us to schedule another patient who is waiting to be treated. There will be a **\$50** charge for a cancellation or "No Show" without proper notice.

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement this appointment/cancellation policy.

I have read and understand the above policy completely and agree to the terms.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Print: \_\_\_\_\_

# INFORMED CONSENT FORM

## What Is Physical Therapy

Physical therapy is a rehabilitation method that helps patients gain or regain the physical activities that they lost or that they are incapable of doing due to defects either from birth or resulting from injuries or disease. There are various methods of treatments to help one to regain and/or improve his or her physical function.

## How Physical Therapy Is Performed

Physical therapy is often done with the help of guided exercises. Some use additional agents such as heat or cold compress, sound waves, electricity, or mechanical devices or machines. This will depend on the issues that are needed to be addressed and the technology available for the physical therapist to utilize.

## The Risks

As physical therapy intends to resolve the problem that the person is experiencing due to illness or injury, there are some risks that may arise during the course of the treatment such as pain and discomfort during the process of therapy. Stretching and twisting may cause some swelling and soreness of stiff muscles. This is normal. There are therapies that may use hot or cold compresses in order to relieve the pain during therapy. Your physician may recommend drugs in order to help you with the pain and swelling while going through the process of physical therapy.

Please take note that some can experience pain and discomfort that may reduce one's motivation to continue due to pain or lack of obvious results. It is important that the person continues with the therapy if it is too early to see the results. It would be best to discuss these matters with your physical therapist.

## Expectations

There are not guaranteed expectations when one undergoes physical therapy treatment. This depends on the situation. But when one undergoes a physical therapy program, it is intended that one will be able to return to his or her prior level of functioning or develop a method to continue what was possible to be performed before the injury. When going through the program, it is important that the patient is truthful with what he or she thinks or feels. Good communication is important for the progress of the patient.

I have read and understand the information given to me and consent to my treatment for physical therapy.

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Campbell's Premier Physical Therapy

## NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW OUR OFFICE WILL PROTECT YOUR HEALTH INFORMATION AND YOUR RIGHTS AS A PATIENT.

### CAMPBELL PHYSICAL THERAPY'S LEGAL DUTY

We are required by law to protect the privacy of your personal health information and will only use that 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.

We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information.

### DISCLOSURE NOT REQUIRING YOUR AUTHORIZATION

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

- To family members or close friends who are involved in your health
- 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
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

### PATIENT'S INDIVIDUAL 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

### CONCERNS AND COMPLAINTS

If you are concerned that we 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 Privacy Officer, Chris Ota at 408-866-5567. If you are still concerned after talking with our Privacy Officer, you may file a written complaint with the Department of Health and Human Services.

### ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Campbell Physical Therapy's Notice of Patient Information Practices. I understand that you 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.

PATIENT NAME: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

(Guardian if patient is a minor):

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Patient Health Questionnaire (PHQ-9)

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

Total Score \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all   
  Somewhat difficult   
  Very difficult   
  Extremely difficult

## Medical History

### Existing or Relevant Previous Conditions

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates. Describe any other conditions:

### Fall History

Injury as a result of a fall in the past year?  Yes  No

Two or more falls in the last year?  Yes  No

Patient at risk for falls?  Yes  No

### Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

### Current Medications

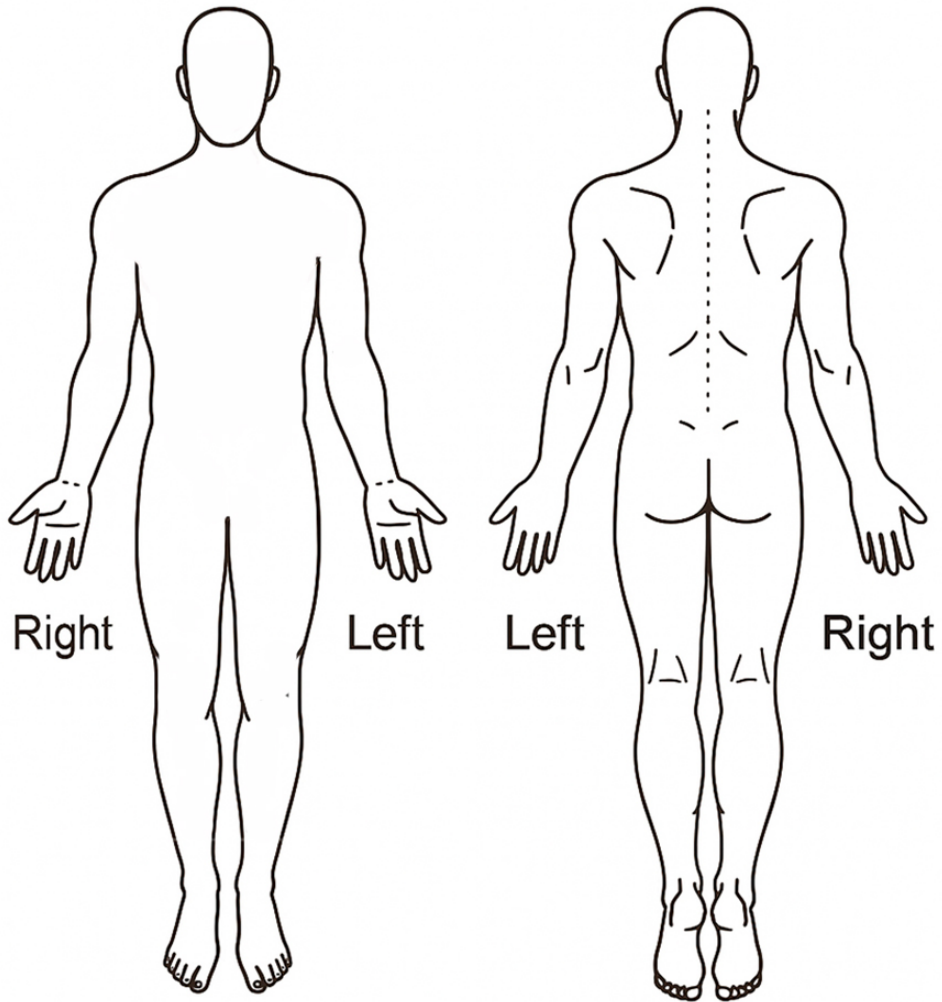
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Instructions:

On the body diagram below, please indicate where your symptoms are located at the present time.



Please rate your pain on a scale from 0 (no pain) to 10 (worst pain imaginable)

present: \_\_\_\_\_ lowest: \_\_\_\_\_ highest: \_\_\_\_\_

over the past 30 days:

Please briefly describe when your symptoms began, cause (if known), what makes you better and worse, treatment received, and any goals you may have for physical therapy.

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