RONNING PHYSICAL THERAPY, INC.
ORTHOPAEDIC & SPORTS REHABILITATION

2505-C Cabrillo College Dr. • Aptos, CA 95003 • (831) 464-3901 • FAX 464-3010

PATIENT INFORMATION SHEET

Patient name _____ Date _____ email _____
Address _____ City/St/Zip _____
Cell phone _____ Other phone _____
Date of Birth _____ Referring physician _____
Parent/Guardian (if minor) _____ SSN _____
Employer _____ Occupation _____
Employer address _____ Work phone _____
Spouse's name _____ Spouse work phone _____
Spouse employed by _____
Date of injury or illness _____ Date of surgery _____
Type of Insurance _____
Emergency contact _____ Emergency phone _____
IS INJURY WORK RELATED YES / NO IF YES, REPORTED TO EMPLOYER YES / NO

I understand that I am responsible for my bill (excluding work comp) _____
Patient signature

Whom may we thank for recommending you to RPT? _____

INFORMED CONSENT

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At RPT, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary from person to person, it is not always possible to accurately predict your response to a certain therapy intervention. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. 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 discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. As you know, there are many alternative treatment approaches within the medical and complimentary medical communities. You have a right to choose the intervention that you prefer, and may ask your therapist at any time if there is another treatment possibility that might be appropriate for you.

I acknowledge that my treatment program has been explained by RPT, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____

Print name *Signature* *Date*

PHYSICAL THERAPY SCREENING QUESTIONNAIRE

Name _____ Date _____ Age _____

Are you pregnant? YES / NO Do you smoke? YES / NO

Do you regularly exercise? YES / NO If so please specify: _____

_____

_____

Current Medications: _____

_____

Past Surgeries: _____

_____

Please circle any of the following conditions that you have or have had:

High blood pressure	Heart disease	Cancer	Stroke	Liver disease
Fibromyalgia	Osteoporosis	Diabetes	Neuropathy	Rheumatoid arthritis

When did your pain start? How? _____

Please circle any of the following problems that you are experiencing:

Numbness/tingling	Bowel/bladder changes	Pain at night
Dizziness/headaches	Unexplained weight loss	Poor balance/falls
		Depression

Are your symptoms changing? (circle one) BETTER / WORSE / NO CHANGE

Have you had X-rays, MRI, or other tests? _____

On the scales below, please circle the number which best represents the severity of your symptoms:

BEST in the last 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

WORST in the last 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What makes you feel better? _____

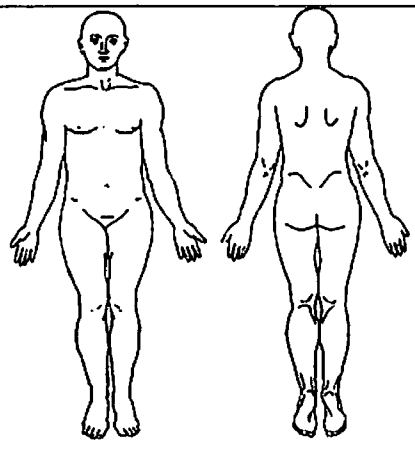
What makes you feel worse? _____

sitting lying down standing walking stress

Please list a few activities that you currently are having difficulty with and that you hope to improve with physical therapy:

1.
2.
3.

Please draw on the accompanying diagram the areas in which you are having pain and are currently seeking physical therapy care:



I have completed this medical history form to the best of my ability/recollection.

Signature _____ Date _____

Ronning Physical Therapy Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Ronning Physical Therapy, Inc., we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may use your information to contact you. For example, we may call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described as above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. Let use know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaints@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Tiffany Hosick, at (831)464-3901 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Ronning Physical Therapy, Inc. Notice of Privacy Practices

Signed_____ Print Name_____ Date_____

If signing as a parent or guardian, please note the name of the patient_____