CAMPBELL'S PREMIER
PHYSICAL THERAPY
163 E HAMILTON AVENUE
CAMPBELL, CA 95008

| PATIENT INFORMATION | | EMAIL ADDRESS: | |
|---|---|---|---|
| First Name: | Last Name: | Middle Initial: | Date: / / |
| Address: | City: | State: | Zip: |
| Birth date: / / | Age: | ☐ Male ☐ Female | S.S. #: - - |
| Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | | Spouse: |
| Chose Clinic Because/ Referred to Clinic By ☐ Dr.: | | ☐ Insurance Plan ☐ Family ☐ Friend | |
| ☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other: | | | |

| WORK INFORMATION | | |
|---|---|---|
| Employer: | Work Phone ( ) - | Ext. |
| Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed | |

| CARE PROVIDER INFORMATION | |
|---|---|
| Referring Dr: | Referring Dr. Phone: ( ) - |
| Regular Dr./PCP | Regular Dr./PCP Phone: ( ) - |

| INSURANCE INFORMATION ( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST ) | | | |
|---|---|---|---|
| Primary Insurance Name: | | | |
| Subscriber's Name (If different): | | | Birth date : / / |
| ID. #: | Group/Policy # | | |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | | | |
| Name of Secondary Insurance: | | | |
| Subscriber's Name: | | | Birth date : / / |
| ID. #: | Group/Policy # | | |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | | | |

| AUTO OR WORK INJURY CLAIM ( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP ) | | | |
|---|---|---|---|
| Insurance Name: ☐ Auto : | | ☐ Labor & Industries: | |
| Adjuster/Claim Manager: | | Phone: | Ext.: |
| Address: | City | State: | Zip: |
| Claim #: | Accident Date: / / | Cause: | |

| ATTORNEY INFORMATION | | | |
|---|---|---|---|
| Name: | Law Firm: | Phone: ( ) - | |
| Address | City | State: | Zip: |

| IN CASE OF EMERGENCY | | |
|---|---|---|
| Name of Local Friend or Relative (Not Living at Same Address): | | |
| Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) - |

I authorize my insurance benefits be paid directly to Campbell Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize Campbell Physical Therapy & SportsCare to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

# Campbell Physical Therapy

## NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW OUR OFFICE WILL PROTECT YOUR HEALTH INFORMATION AND YOUR RIGHTS AT 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

# MEDICARE BENEFITS

## Medical Necessity

Physical Therapy visits will be provided according to the medical doctor's request. Therefore, a doctor's referral is necessary in order to be seen in our office.

## Physical Therapy Benefits

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 insurance, it is your responsibility to pay for the services.**

I have read and understand my quoted benefits. A copy of this form is available to you.

_____ _____

Print Name Signature

_____

Date

# 24 Hour Cancellation and "No Show" Policies

The following are our policies regarding cancellations and no-shows. These policies are in effect because each time a patient misses an appointment without prior advance notice, another patient is prevented from receiving care.

- **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 $20 charge for a cancellation without proper notice. This charge will not be paid by your insurance and must be paid prior to your next appointment.**

- **A "no-show" is a missed appointment without a 24 hour notice. "No-shows" also inconvenience other patients who may need access to medical care in a timely manner. Therefore, our policy allows only two LATE cancellations or two "no-shows". After that, we will not be able to schedule your visits in advance. We will still treat you, but you will need to call us on a day you are available to see if we have an open appointment to see you. If not, you will need to call on another day.**

Our goal at Campbell Physical Therapy is to provide quality medical care in a timely manner. In order to do so, we have had to implement this appointment/cancellation policy. This policy enables us to better serve you and our other patients with consistent and timely care.

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

Signed: _____ Date: _____

Print: _____

# COVID-19 Screening Form

**For new Patients: You are required to fill out this screening questionnaire before your first visit and then notify us before future visits if anything changes.**

Name*_____Email*_____

**Please carefully read and answer ALL following questions:**

1. Have you had close contact with anyone with acute respiratory illness or someone who has travelled outside of the United States in the past 14 days?
   YES NO
2. Have you had COVID 19 or come in contact with a confirmed or suspected case of COVID 19 in the past 2 weeks?
   YES NO
3. Do you currently have ANY of the following symptoms?
   Fever •New onset of cough •Worsening chronic cough •Shortness of breath •Difficulty breathing •Sore throat •Difficulty swallowing •Decrease or loss of sense of taste or smell •Chills •Headaches •Unexplained fatigue/malaise/muscle aches (myalgias) •Nausea/vomiting, diarrhea, abdominal pain •Pink eye (conjunctivitis) •Runny nose/nasal congestion without other known cause
   YES NO
4. Does anyone living in your household have ANY of the above symptoms?
   YES NO
5. If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?
   YES NO

If you answer "YES" to any of above questions, we ask you to call your primary care provider for further clinical assessment.

**Declaration:**

1. I have answered all the above questions honestly and truthfully and by signing below, I consent and accept the physical therapy treatments in light of the COVID-19 Pandemic.

Signature Date

# 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_____

# Patient Health Questionnaire-2 (PHQ-2)

| 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 |

*For office coding:* _____*0*_____+_____+_____+_____

*= Total Score* _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

# 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

| ELDER ABUSE SUSPICION INDEX © (EASI) | | | |
|---|---|---|---|
| **EASI Questions**<br>**Q.1-Q.5 asked of patient; Q.6 answered by doctor**<br>**Within the last 12 months:** | | | |
| 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO | Did not answer |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? | YES | NO | Did not answer |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO | Did not answer |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO | Did not answer |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO | Did not answer |
| 6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? | YES | NO | Not sure |

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com



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PATIENT NAME: _____ DATE OF BIRTH: _____

## MEDICAL HISTORY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | ○Yes ○No | Depression | ○Yes ○No | Kidney Problems | ○Yes ○No |
| Anemia | ○Yes ○No | Diabetes | ○Yes ○No | Metal Implants | ○Yes ○No |
| Anxiety | ○Yes ○No | Dizzy Spells | ○Yes ○No | MRSA | ○Yes ○No |
| Arthritis | ○Yes ○No | Emphysema/Bronchitis | ○Yes ○No | Multiple Sclerosis | ○Yes ○No |
| Asthma | ○Yes ○No | Fractures | ○Yes ○No | Osteoporosis | ○Yes ○No |
| Cancer | ○Yes ○No | Gallbladder Problems | ○Yes ○No | Parkinson's | ○Yes ○No |
| Cardiac Conditions | ○Yes ○No | Hepatitis | ○Yes ○No | Rheumatoid Arthritis | ○Yes ○No |
| Cardia Pacemaker | ○Yes ○No | High Cholesterol | ○Yes ○No | Seizures | ○Yes ○No |
| Chemical Dependency | ○Yes ○No | High Blood Pressure | ○Yes ○No | Strokes | ○Yes ○No |
| Circulation Problems | ○Yes ○No | HIV/AIDS | ○Yes ○No | Thyroid Disease | ○Yes ○No |
| Currently Pregnant | ○Yes ○No | Incontinence | ○Yes ○No | Tuberculosis | ○Yes ○No |
| | | Covid | ○Yes ○No | Vision Problems | ○Yes ○No |

**Describe any other conditions or precautions:**

**Fall History**

**Injury as a result of a fall in the past year?** ○Yes ○No **Date of Fall:** _____

**Two or more falls in the last year?** ○Yes ○No **Date of Falls:** _____

**Surgical History**

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

**Current Medications**

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

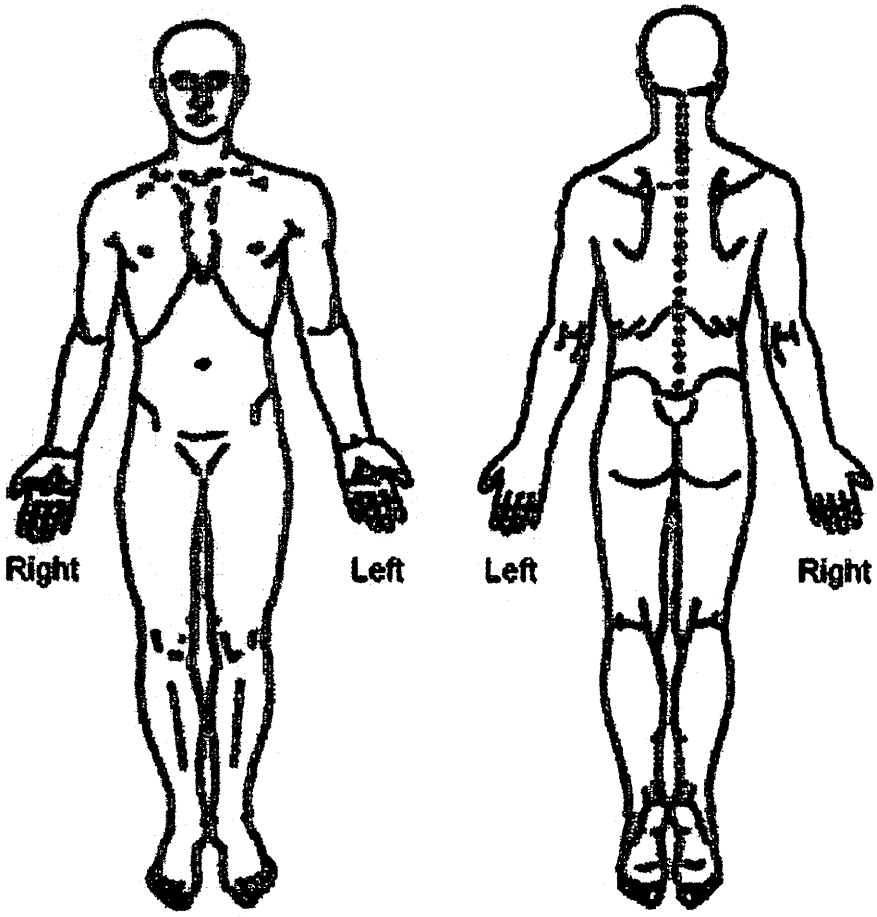
Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

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 O (no pain) to 10 (worst pain Imagineable)**

**present:_____lowest:_____highest:_____**

**over the past 30 days•**

**Please briefly describe when your symptoms began, cause (If known), what make's you better and worse, treatment received, and any goals you may have for physical therapy.**

_____

_____

_____

_____