Campbell's Premier Physical Therapy

163 E. Hamilton Avenue
Campbell, CA 95008
(408) 866-5567

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's Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Campbell's Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE 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 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

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's Premier 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: _____

IMPORTANT

INSURANCE INFORMATION

I have chosen to have Campbell's Premier Physical Therapy bill my private PPO health insurance to cover my physical therapy visits.

I have verified my insurance and believe they will pay for my therapy. However, I understand that if my insurance does not pay for any of my visits, for any reason, I am responsible to make those payments and will be billed for them.

Name (please print): _____

Signature: _____

Date: _____

Campbell's Premier Physical Therapy
163 E Hamilton Avenue
Campbell, CA 95008
Ph 408-866-5567 F 408-866-1317

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 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: _____

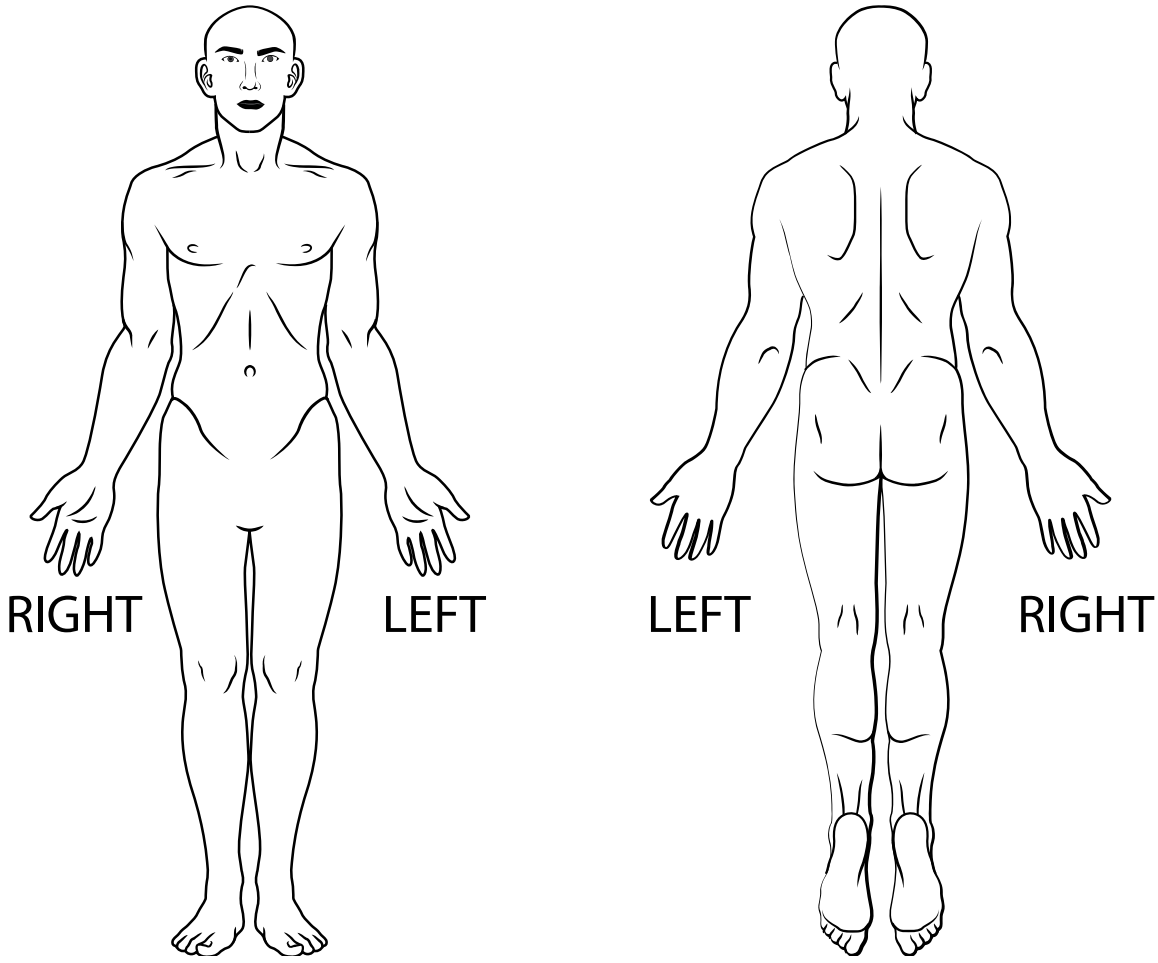
Drug: _____ Dosage: _____ Reason for Taking: _____

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.

_____

_____

_____

_____