1635 Creekside Drive #101
Folsom, CA 95630
Phone: (916) 983-5611
Fax: (916) 983-5615

PATIENT INFORMATION			
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	Email:
Home Phone: ( ) -	Cell/Work Phone: ( ) -	Spouse:	

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

PRIMARY PHYSICIAN	
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 ROC Physical Therapy. I understand that I am financially responsible for any balance. I also authorize ROC Physical Therapy to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Cancer (presently or history of)	☐	☐

Other:

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day 1-
☐ 2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week 3-
☐ 4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week 5+
☐ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐YES ☐NO week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where: _____

PATIENT / GUARDIAN SIGNATURE DATE

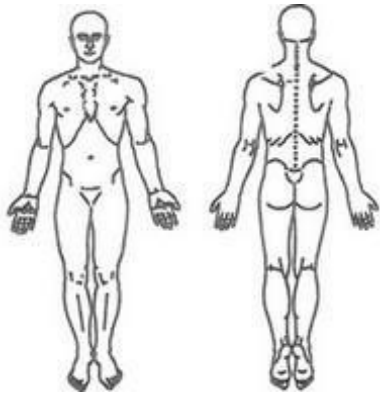
Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMMMM	--- --- ---	0 0 0 0
_____	Stabbing	Other
	/ / / / / / /	x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is _____

Date First Symptom of your problem occurred on: _____

2nd Complaint _____

3rd Complaint _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please list all of your prescribed and over-the-counter medications.
You may also provide a typewritten list in lieu of completing this form.

Medication Name	Dose, Frequency and Method of Administration

Physical Therapy

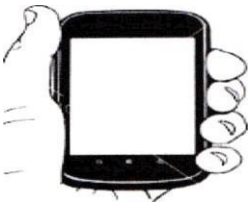
Treating our patients *the way we wont to be treated*

Message Content

ROC Physical Therapy partners closely with patients to ensure that treatment plans, directives, appointments, and other important care-related matters are effectively communicated. Below is a general guideline of our policy regarding how our office utilizes various methods of contact, and the content such contacts may contain.

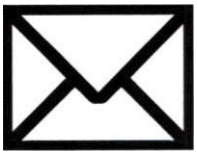
Voice Mail

We may leave messages at the phone number you designate as your preferred or “primary" phone number to confirm appointments. Voice mail confirmations may include our business name and phone number, but we will not release medically specific information on your voice mail.



Text Messaging

We may arrange for youtoreceive appointment confirmations bytext message. These messages may include our business name, address and phone number, as well as your specific appointment date and time. While the message layout and content may occasionally change, it will not contain medically specific information.



E-Mail Messaging

We may arrange for you to receive appointment confirmations by E-mail message. These messages may include our business name, address and phone number, as well as your specific appointment date and time. While the message layout and content may occasionally change, it will not contain medically specific information.

Your Privacy Is Important

At ROC Physical Therapy, your privacy is of the utmost importance to us. We will make all reasonable attempts to protect your health and demographic information in the process of communicating appointments and other care-related information. Thank you for understanding that ROC Physical Therapy cannot be held responsible for protecting your e- mail, cell phone and other message devices from being viewed by others.

PATIENT / GUARDIAN SIGNATURE DATE

Appointment Scheduling, Cancellation and No-Show Policy

To Our Valued Patients

ROC Physical therapy has based its philosophy on the idea of one-on-one care for each and every patient, and our primary goal is to provide quality therapy services. We appropriately structure our schedule to ensure that every patient has maximum time with the therapist. We strive to ensure that we provide services in a timely manner. To help us continue to succeed providing the very best of care, please familiarize yourself with our cancellation/no-show policy:

- Cancellations must be made 48 hours prior to your scheduled appointment.
- Cancellations that occur one workday prior to the scheduled appointment are subject to a cancellation fee of $50.00.
- If you fail to attend a scheduled appointment, you may be assessed a $50.00 "No Show" fee.
- If you fail to attend two or more appointments, you may be subject to discharge from care, with noncompliance notification being sent to your attending medical provider, insurance carrier(s), adjustor (in the case of workers' compensation), and other entities who may require notification.

Authorization and Assignment of Benefits

I hereby authorized ROC Physical Therapy personnel to provide treatment as prescribed by my ordering medical provider.

I hereby assign all insurance benefits (or services rendered to which I am entitled) to be paid directly to ROC Physical Therapy.

I understand that if my insurance company(s) / third party payer denies payment, that I am personally responsible for the balance.

I hereby authorize the release of medical records to ROC Physical Therapy, and for ROC Physical Therapy to release, pertinent information concerning my care for the purposes of treatment, payment and operations.

<u>The following does not apply to Workers' Compensation Clients</u>:

I understand that I am legally responsible for payment for all services rendered by ROC Physical Therapy. If my insurance is being billed, I will be responsible for paying any remaining balance deemed by my insurance to be patient responsibility including but not limited to copays, co-insurance, deductible, and services not covered under the terms of my coverage. I understand that copays and/or co-insurance are due at the time of service.

PATIENT / GUARDIAN SIGNATURE DATE

Acknowledgement of Receipt of Notice of Privacy Practices

As part of my health care, Rehabilitation and Occupational Consultants-ROC Physical Therapy ("The Company") creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information services as a basis for my continuing care. I understand that this information issued as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third-party companies to assure that a service billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have a right to review this Notice of Privacy Practices before singing this consent.

I understand that The Company may change its Notice of Privacy Practices at any times and that a current copy will be available for my inspection during regular business house of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Rehabilitation and Occupational Consultants-ROC Physical Therapy and agree to the liability limitations explained therein.

PATIENT / GUARDIAN SIGNATURE DATE