This form may be filled out electronically. Please complete necessary fields and:

- **Print** form, then mail or bring to Dublin Physical Therapy
- **Email** completed form to Dublin Physical Therapy

Dublin Physical Therapy

6759 Sierra Court, Suite A, Dublin, CA 94568
Ph: 925.803.0530 • Fax: 925.803.2047
www.dublinptinc.com

PATIENT INFORMATION

Date_____

Name _____
(First) (Last) (Middle Initial)

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____ Fax # _____

Social Security # _____ Sex M ❑ F ❑ Birth Date _____

Marital Status M ❑ S ❑ W ❑ D ❑ Spouse's Name _____

Emergency Contact Name _____ Emergency Contact # _____

Where did you hear about us? _____

Have you been treated at Dublin Physical Therapy before? Yes ❑ No ❑

EMPLOYMENT INFORMATION

Employer/School _____ Occupation _____

Dept. _____ Address _____

City _____ State _____ Zip _____

Status: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Disability ❑ Unemployed

MEDICAL INFORMATION

Referring Physician _____

Address _____ Phone _____ Fax _____

City _____ State _____ Zip _____

Date of Injury/ Surgery _____ Workers Comp Yes ❑ No ❑

Auto Accident: Yes ❑ No ❑ Lawsuit: Yes ❑ No ❑ Employer _____

Attorney's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company Name _____

Name of Policy Holder _____DOB:_____ Relationship _____

Claims Address _____State: _____Zip: _____

Ins. Co. Phone _____ID # _____Group # _____

Secondary Insurance Company Name _____

Name of Policy Holder _____DOB:_____ Relationship _____

Claims Address _____State: _____Zip: _____

Ins. Co. Phone _____ID # _____Group # _____

WORKER'S COMPENSATION/ AUTO ACCIDENT

Insurance Company Name _____

Worker's Compensation is through: (Employers Name) _____

Claims Adjuster Name _____ Phone _____

Claims Address _____

Fax # _____ Claim # _____

Nurse Case Manager's Name _____ Phone _____Fax # _____

DUBLIN PHYSICAL THERAPY POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits as well as file therapy claims for you; however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require **24-HOUR NOTICE** for any cancellation. A **$75.00 fee** will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. Additional treatment authorization signatures are required by a parent/ legal guardian for all minors.

Patient Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Print Full Name _____

DUBLIN PHYSICAL THERAPY

KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please be aware to give 24 hours notice if you are unable to attend your appointment or it will result in a $75.00 charge.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and therapist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

Patient Signature _____ Date _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

❑ Home Telephone _____

❑ OK to leave a message with detailed information

❑ Leave message with callback number only

❑ Work Telephone _____

❑ OK to leave message with detailed information

❑ Leave message with callback number only

❑ Written Communication

❑ OK to mail to my home address

❑ OK to mail to my work/office

❑ OK to fax to this number_____

❑ Other_____

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The Privacy Rule generally requires providers to take reasonable steps to limit the use or disclosure of, and requests for PHIto the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.Healthcare entities must keep records of PHI disclosures, Information provided below, if completed properly, will constitute adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

FOR OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosure to Whom Address or Fax Number	1	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	2	3

(1) Check this box if the disclosure is authorized

(2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

NOTICE OF PRIVACY PRACTICES

Dublin Physical Therapy, Inc.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Dublin Physical Therapy is informing you of your privacy rights. Please review the information below.

What is HIPAA? HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). PHI is confidential information about a patient, including demographic information.

What are my rights under HIPAA? Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

YOUR RIGHTS

- You have a **right to inspect and obtain a copy of your PHI**. We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.
- You have a **right to request an amendment of PHI**. If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
- You have the **right to know what disclosure(s) of your PHI have been made**. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/ correctional facilities, or disclosures made prior to April 14, 2003.
- You have a **right to request confidential communications of PHI**. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
- You have a **right to request restrictions on the use and disclosure of PHI**, however we are not required to agree to your request. Your request must state specific restrictions requested and whom the restrictions would apply.
- You have a **right to receive a hard copy of this notice**.

How will Dublin Physical Therapy Use and Disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of **Treatment, Payment and Healthcare Operations**. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of **Treatment, Payment and Healthcare Operations**. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

USE AND DISCLOSURE OF PHI

- **Disclosure to those Involved in the Individual's Care** – when necessary, we make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.
- **Uses and Disclosures Required by Law** – as required by law we are required to use and disclose PHI for the following reasons
- **Use and Disclose PHI for Public Health Activities** – Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
- **Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence** – Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
- **Uses and Disclosure of Health Oversight Activities** – we may use and release PHI to be used for audits, investigations, licensure issues, etc.
- **Disclosure for Judicial and Administrative Proceedings** – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
- **Disclosure for Law Enforcement Purposes** – we may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
- **Uses and Disclosures Related to Decedents** – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
- **Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations** – we may use and release PHI in order to facilitate organ, eye or tissue donations.
- **Uses and Disclosures to Advert a Serious Threat to Health or Safety** – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
- **Uses and Disclosures for Specialized Government Functions** – we may use and release PHI for military / veterans activities and national security / intelligence activities.
- **Use and Disclosure of PHI in Emergency Situations** – in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
- **Uses and Disclosures of PHI for Marketing Purposes** – Dublin Physical Therapy will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
- **Uses and Disclosures of PHI for Research Purposes** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
- **Uses and Disclosures requiring the Patients Authorization** – we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of Dublin Physical Therapy? Dublin Physical Therapy must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint? If you feel your privacy rights have been violated, contact the regional Department of Health and Human Services at 312-886-2359 or www.hhs.gov .

Receipt of Notice of Privacy Practices Form

Effective April 14, 2003, I, _____, hereby acknowledge receipt of Dublin Physical Therapy's Notice of Privacy Practices. Dublin Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Dublin Physical Therapy has reserved the right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Dublin Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Dublin Physical Therapy.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient _____

PERMANENT MEDICAL HISTORY

Dublin Physical Therapy, Inc.

Name _____ Age_____ Date _____

Referring Dr _____Date of Injury_____

What is your main complaint or problem? _____

Date of onset_____How did it occur? _____

Date of surgery _____Type _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

HIGH BLOOD PRESSURE_____ ALLERGIES TO HEAT_____ DIABETES_____ ALLERGIES TO ICE_____

HEART ATTACK_____ OTHER ALLERGIES_____ HEART DISEASE_____ PACEMAKER_____

HERNIA_____ HEADACHES_____ METAL IMPLANTS_____ KIDNEY PROBLEMS_____

CANCER_____ NERVOUS DISORDER_____ PREVIOUS SURGERIES_____ SEIZURES_____

ARE YOU CURRENTLY PREGNANT? _____

ARE YOU CURRENTLY TAKING MEDICATIONS? _____ IF YES, PLEASE LIST THEM

_____

What is your occupation?_____

Working: Full-time Part-time Light duty Not working

Job requires: Sitting Standing Bending Walking Lifting Squatting

Physical requirements: Sedentary Light Moderate Heavy Very Heavy

If you have pain, please circle the words that best describe it.

Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache Tingle Tight

In general, please rate the level of your pain at its best and worst.

Mild Moderate Worst Imaginable Pain

0 1 2 3 4 5 6 7 8 9 10

In general, how do you feel in the: Mornings: better/worse **Afternoons:** better/worse **Evenings:** better/worse **Night:** better/worse

What activities aggravate your symptoms? _____

_____

What activities make your symptoms better? _____

_____

What functional activities are you currently having problems with?

Dress/ bathe job duties housework cook/eat walk stand

sit drive sleep recreation _____

Have you been treated for these symptoms before? Yes No

If so, where, and do you feel it helped? _____

_____

Have you had any other injuries? If so, please briefly describe:

_____

If female, are you pregnant or trying to be? Yes No

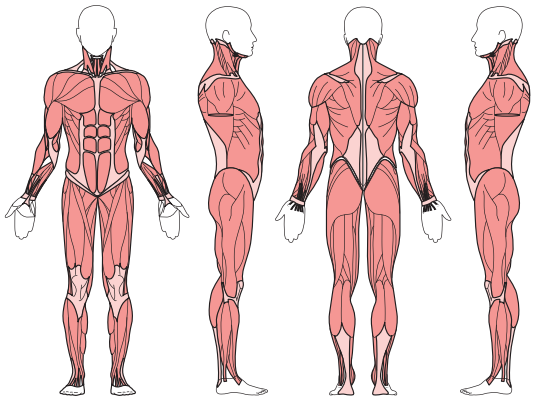
Do you have another appointment with your doctor? Yes No When?

_____

What do you hope to accomplish with physical therapy treatments?_____

_____

Please Indicate Painful Areas



THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND BY MY SIGNATURE BELOW, I AM FULLY CONSENTING TO TREATMENT BY DUBLIN PHYSICAL THERAPY INC. MY TREATMENT IS UNDER THE DIRECTION OF MY PHYSICIAN

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Pelvic Floor Therapy Questionaire

Dublin Physical Therapy, Inc.

Patient Name _____ Date _____

Age _____ Weight _____ Height _____ BMI _____

What is the problem you are seeking physical therapy for? When did the problem begin? When did it get worse? What treatments or previous physical therapy have you had for this condition? _____

_____

_____

HISTORY

Number of pregnancies _____ Number of vaginal deliveries _____ Number of cesarean deliveries _____

Birthweight of babies _____ Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery? Y___ N___ Are you having regular periods/menstrual cycles? Y___ N___

Do you have a history of sexual abuse or trauma? Y___ N___ Do you have frequent urinary tract infections? Y___ N___

Have you ever had any urogynecological surgeries? Y___ N___

If so, what kind and when? _____

Do you have, or have you had, any of the following? (Please check all that apply)

High blood pressure ___ Allergies to heat/ice ___ Diabetes ___

Heart attack ___ Other allergies ___ Heart disease ___

Pacemaker ___ Hernia ___ Headaches ___

Metal implants ___ Kidney problems ___ Cancer ___

Nervous disorder ___ Previous surgeries ___ Seizures ___

Have you had any other injuries? If so, please briefly describe:

_____

_____

_____

Are you currently pregnant? ☐

Are you currently taking medications? ☐ If yes, please list them:

_____

_____

What is your occupation? _____

PAIN

Do you have pain with: Sexual intercourse Y ☐ N ☐ Pelvic exam Y ☐ N ☐ Tampon use Y ☐ N ☐

Back, leg, groin, abdominal pain Y ☐ N ☐

BLADDER SYMPTOMS

Do you lose urine when you: Cough/ sneeze/ laugh Y___ N___

Lift/ exercise/ dance/ jump Y___ N___

On the way to the bathroom Y___ N___

Hear running water Y___ N___

Other _____ Y___ N___

Have a strong urge to urinate Y___ N___

Do you wet your bed Y___ N___

Difficulty starting a stream of urine Y___ N___

Feel unable to empty bladder fully Y___ N___

Have pain with a full bladder Y___ N___

Have an urgency of urination (a strong urge to urinate) Y___ N___

Have burning/ pain with urination Y___ N___

Strain to empty your bladder Y___ N___

Have a falling out feeling Y___ N___

Urinate more than 8 times/day Y___ N___

BOWEL SYMPTOMS

Strain to have a bowel movement Y___ N___

Include fiber in your diet Y___ N___

Have constipation often Y___ N___

Leak gas by accident Y___ N___

Have a very strong urge to move your bowels Y___ N___

Most common stool consistency: liquid___ soft___ firm___ pellets___ other _____

Leak/ stain feces Y___ N___

Have diarrhea often Y___ N___

Take laxatives/ enema regularly Y___ N___

Have pain with bowel movement Y___ N___

How often do you move your bowels: _____ per day/ week

What do you hope to accomplish with physical therapy treatment? _____

_____

_____

_____

_____

_____

_____

The above information is correct to the best of my knowledge. I understand by my signature below, I am fully consenting to treatment by Dublin Physical Therapy Inc. My treatment is under the direction of my physician.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

Pelvic Floor Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and ____ choose ____ refuse this option.

Date: _____ Patient Name _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature