Debora Chasse DPT, WCS, CLT-LANA

Welcome to Function Ability Physical Therapy. We want to assist you with your current and future health concerns. Our focus is health improvement, maintenance, prevention, and education. Any current health problems may be indicators of underlying imbalances. Part of our responsibility will be to assess your musculoskeletal health status, find the root cause for your complaints, and to advise you on physical therapy treatment options to ensure optimal well-being. During the course of your examination and treatments, please feel free to comment, ask questions, and provide us with feedback. The more you know about yourself, the more active a role you can play in restoring and maintaining your own health. Together we can form a team on the side of a healthy future.

Name: _____

Phone number: _____

Address: _____

Email: _____

Referring Physician: _____

Consent for care and treatment

I, the undersigned, do hereby agree and give my consent for Function Ability Physical Therapy to administer medical care and treatment, which is considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

2230 W. Chapman Ave., Ste. 221, Orange, CA 92868
Office: (714) 812-9887 • Fax: (714) 849-5394

Patient's Name: _____

HIPPA Notice of Privacy Policies

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Function Ability Physical Therapy Legal Duty

Function Ability Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. Function Ability Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law. Function Ability Physical Therapy may change its policy at any time. When changes are made, a new Notice of Privacy Policies will be given to all current patients at their next visit. You may also request an updated copy of our Notice of Privacy Policies at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Function Ability Physical Therapy will consider all such requests on a case-by-case basis, but Function Ability Physical Therapy is not legally required to accept them.

Concerns and Complaints

If you are concerned that Function Ability Physical Therapy 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 practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Permission for Messages

I give permission to Function Ability Physical Therapy to leave messages concerning my appointment times:

□ Home voicemail □ Cell voicemail □ Work voicemail

Patient's Signature: _____ Date: _____

Patient's Name: _____

2230 W. Chapman Ave., Ste. 221, Orange, CA 92868
Office: (714) 812-9887 • Fax: (714) 849-5394

Patient's Name: _____

Attendance and Cancellation Policy

We are glad you have chosen Function Ability Physical Therapy to provide you with high-quality individualized medical care. We value you and the time you have chosen is specifically reserved for you. It is important to be consistent with your physical therapy treatments.

Thank you for your compliance with the following policies regarding cancellation and no-shows.

- A **late** is considered when a patient fails to cancel their scheduled appointment with a 48-hour advance notice. If this occurs, the patient will be charged a $50.00 fee.
- Your treatment begins at the time your appointment is scheduled. To avoid traffic problems, please plan to arrive 15 minutes prior to your appointment time.
- TriWest patients will be discharged from physical therapy when they have three no-show occurrences.

Payment Policy

Function Ability Physical Therapy is contracted with TriWest insurance company. All other insurance companies will consider your physical therapy treatment out of network. We cannot guarantee that your insurance company will pay for our services.

Regarding insurance companies who authorize a contract under special circumstances:

I authorize payment of benefit to be made directly to Function Ability Physical Therapy for services rendered. I guarantee that I will immediately reimburse Function Ability Physical Therapy for any benefits assigned to me.

I will be responsible for the deductible amounts, co-insurance percentages, and the remaining balance not paid by the insurance company. The entire balance on the account remains the sole responsibility of the patient.

Regarding cash pay patients*: I understand that I am ultimately responsible for payment of services rendered to me. I expressly guarantee payment of my account and agree to pay any charges left unpaid, in whole or in print.*

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

2230 W. Chapman Ave., Ste. 221, Orange, CA 92868
Office: (714) 812-9887 • Fax: (714) 849-5394

Patient's Name: _____

Direct Physical Therapy Treatment Services

Pursuant to Section 2620 of the California Code of Regulations.

"You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

"Under California law, you may continue to receive direct physical therapy treatment for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care, and that an in-person patient examination and evaluation was conducted by the physician, surgeon, or podiatrist." (*added by Stats. 2013, Ch. 620, Sec. 4. Effective January 1, 2014*).

Please note: These conditions do not apply to a physical therapist when he or she is providing wellness physical therapy services to a patient.

Your physical therapist has the final decision to request a prescription from patient's physician if she/he feels it is in the best interest of patient care and practice.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

Optional Research Consent Form

Function Ability Physical Therapy is dedicated to continuing education in effective physical therapy treatment techniques and success rates. Please carefully review the following components of our research materials (video, photo and case study data) and decide if you would be willing to participate in future studies by allowing us to use your medical information. Thank you.

Print participant's name: _____

I hereby authorized Function Ability Physical Therapy to take photographs and or videos of my treatment and authorize Function Ability Physical Therapy to use and publish the photographs and/or videos taken of me for their printed materials, websites, lecture presentations, training courses and other educational purposes. I acknowledge that Function Ability Physical Therapy may use such photographs and/or videos of me with or without my name for purposes such as publicity, education,

Patient's Name: _____

illustration, advertising and web content. I further agree that my participation in any photographs and/or videos produced by Function Ability Physical Therapy confers upon me no rights of ownership whatsoever. I acknowledge that since my participation in printed materials and web pages produced by Function Ability Physical Therapy is voluntary, I will receive no financial compensation. I release Function Ability Physical Therapy, its contractors and it employees from liability for any claims by me or any third party in connection with my participation. I give permission to Function Ability Physical Therapy to use my medical information for the purpose of research and case studies in order to educate colleagues about effective physical therapy techniques. I acknowledge that my name and identity will remain private and anonymous. I understand that my participation in any research conducted by Function Ability Physical Therapy is completely voluntary and will not affect my treatment or patient status.

Please check the following boxes indicating your consent:

□ Photos □ Videos □ Case Studies

Health and Lifestyle Questionnaire

Please complete this questionnaire with care. Your answers will help your physical therapist to determine the most effective care for you. Please print. Thank you.

Height: _____Weight: _____

Are you satisfied with your present weight? Yes No

Have you ever had a weight problem? Yes No

Do you exercise regularly? Yes No How often? _____

What type of exercise program? _____

What are the things you find stressful? _____

What things do you do for relaxation? _____

List your hobbies _____

How many hours of sleep do you get per night? _____

What are your health concerns, in order of importance to you?

1. _____

Patient's Name: _____

2. _____

3. _____

4. _____

5. _____

If there is a specific condition, how long has it been occurring? _____

Have you had similar problems before? Yes No

Do you have relative with similar problems? Yes No

What do you feel the causes of your health problems are? _____

_____

When did you last feel well? _____

Severity of condition: (0 - no pain to 10 - unbearable pain) _____

Past Accidents/Injuries with dates:

Description: _____

Description: _____

Description: _____

Past Surgeries with dates:

Description: _____

Description: _____

Description: _____

Past Hospitalizations:

Description: _____

Description: _____

Patient's Name: _____

Past Infections/Major Illnesses:

Description: _____

Description: _____

Description: _____

Past Conditions and Diseases (please circle):

High blood pressure	Heart disease	Seizures
Sensitivity to temperatures	Heart attack	Cancer
Loss of consciousness	Pacemaker	Diabetes
Balance problems	Dizzy spells	Pregnancy
Kidney problems	Headaches	Hernia
Nervous disorder	Vision problems	Metal implants
Hearing problems	Balance problems	Celiac disease

Other _____

Medications, list name and dosage

_____

_____

_____

_____

Allergies (please list any allergies)

_____

_____

_____

2230 W. Chapman Ave., Ste. 221, Orange, CA 92868
Office: (714) 812-9887 • Fax: (714) 849-5394

Patient's Name: _____

Tests/Exams

Have you had X-rays, MRIs or full body scans in the past 3 years? Yes No

What did the images reveal? _____

Date of last pelvic/prostate exam: _____

Date of last dexa scan/bone density test: _____

Date and results of any other recent tests: _____

Do you have leakage problems or urgency to get to the bathroom? Yes No

If yes, please explain: _____

Are you constipated? Yes No

Number of bowel movements per day? _____

Do you drink coffee, black tea or soda? _____

Do you smoke? Yes No How many per day? _____

Do you drink alcohol? Yes No Weekly amount? _____

If you are a female, please complete the following.

Date of last mammogram: _____

Date of last menstrual cycle: _____

How many pregnancies have you had? _____

Were there any complications? _____

Family history on next page.

Patient's Name: _____

Family Medical History

If there is a history of any of the following in your family, please check and state the relationship of the family member. Please circle appropriate items.

Alcoholism	Celiac	Mental Disease
Allergies	Colitis	Muscular Dystrophy
Arteriosclerosis	Depression	Multiple Sclerosis
Arthritis	Diabetes	Schizophrenia
Asthma	Epilepsy	Stomach Ulcers
Bed Wetting	Heart Disease	Stroke
Candida Albicans	Hyperactivity	Tuberculosis
Cancer	Kidney	Yeast Infections
Cataracts	Learning Disability	Venereal Disease

Is there any other information you would like us to know? _____

_____

_____

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

2230 W. Chapman Ave., Ste. 221, Orange, CA 92868
Office: (714) 812-9887 • Fax: (714) 849-5394