QUAIL RUN
PHYSICAL THERAPY

Date _____ Cell Phone _____ Home Phone _____ Work Phone _____

Patient _____
Last Name First Name Middle Initial

Responsible Party (if patient is a minor) _____

Physical Address _____ Mailing _____

City _____ State _____ Zip Code _____

Age _____ DOB _____ Single ___ Married ___ Widowed ___ Divorced ___

Responsible Party _____ Relationship to Patient _____ DOB _____

Patient SS# _____ Responsible Party SS# _____

Referring Dr. _____ Diagnosis _____ Date of Injury or Surgery_____

Employer _____ Injury related to work? Yes __ No__

Is this injury due to a motor vehicle accident? Yes__ No __ If (yes) is litigation involved? Yes __ No __

AttorneyName/Address/Phone _____

The above information is true and correct to the best of my knowledge. I authorize my insurance benefits to be paid directly to Quail Run Physical Therapy. I understand that I am financially responsible for any balance per coordination of benefits with my insurance company, including all co-pays and deductibles. I also authorize Quail Run Physical Therapy to release any information to my insurance company that may be required to process my claim(s).

_____ _____
Patient/Guardian Signature Date

OFFICE USE ONLY

Primary Insurance _____ **ID/Claim#** _____ **Group#** _____

Address/Phone & Fax# _____

Adjustor (If applicable) _____

Eff Date _____ **Ded** _____ **Met** ____ **Cov%** ___ **Rx Req** ___ **# Visits** ___ **Co-pay** ___ **Aqua/Chiro** ___

Seconday Insurance _____ **ID/Claim#** _____ **Group#** _____

Address/Phone & Fax# _____

Adjustor (If applicable) _____

Eff Date _____ **Ded** _____ **Met** ____ **Cov%** ___ **Rx Req** ___ **# Visits** ___ **Co-pay** ___ **Aqua/Chiro** ___

Date 1st Seen _____ **New Pt** ____ **New Case/New Dx** ____ **Return Pt** ___

Referring Dr. _____ **NPI** _____ **Phone#** _____

P.O. BOX 1560 • 422 LAKEPORT BLVD. • LAKEPORT, CA 95453 • (707) 263-6845 • (707) 263-6451 FAX

www.quailrunphysicaltherapy.com

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Patient Medical Information

Federal regulations require a medical history must be included in all patient's medical records.

Patient Name_____ Date_____

Height_____ Weight_____ Birthdate _____ Current age_____

Date of onset/injury/surgery:_____

Do you have or have had any of the following:

Arthritis	Yes____ No____	Osteoarthritis	Yes____ No____
Diabetes	Yes____ No____	Sensitive Heat/Ice	Yes____ No____
High Blood Pressure	Yes____ No____	Pregnant	Yes____ No____
Heart Disease	Yes____ No____	Other Allergies	Yes____ No____
Heart Attack	Yes____ No____	Previous surgery	Yes____ No____
Pacemaker	Yes____ No____	Seizures	Yes____ No____
Headaches	Yes____ No____	Metal Implants	Yes____ No____
Kidney Problems	Yes____ No____	Cancer	Yes____ No____
Nervous Disorders	Yes____ No____	Hernia (ventral, inguinal, etc)	Yes____ No____
Breathing Problems	Yes____ No____	Other_____	

If yes to any above, please explain and give approximate dates _____
_____
_____

Are you presently taking medications? Yes____ No____ If yes, list what medications and for what conditions _____
_____

Are you currently receiving Home Health Care, or any type of in home services? Yes____ No___
If yes, please specify._____
_____

Have you received Chiropractic care this year?_____

Have you received Physical Therapy this year? _____

In case of emergency, who should be notified? _____ Phone_____

I certify that the above information is true and correct to the best of my knowledge.

Patient signature_____ Date_____

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NOTICE OF PATIENT INFORMATION PRACTICES

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.

LEGAL DUTY

Quail Run Physical Therapy us required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Quail Run Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting administrative activities and evaluating the quality of care that we provide. For example, Quail Run Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Quail Run Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Quail Run Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Quail Run Physical Therapy may change its policy at any time. When any changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit if you ask. You may also request an update of the Notice of Information Practices at anytime.

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 do 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. Quail Run Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

QUAIL RUN
PHYSICAL THERAPY

CONCERNS AND COMPLAINTS

If you are concerned that Quail Run 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 Melissa Schweitzer at Quail Run Physical Therapy. You may also send a written complaint to the US Dept. of Health & Human Services.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Quail Run Physical Therapy's Notice of Information Practices. I understand that Quail Run Physical Therapy 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. I also understand that Quail Run Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Quail Run Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Patient Name Patient/Guardian Signature

ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to Quail Run Physical Therapy. I understand that I am financially responsible for any balance per coordination of benefits with my insurance company, including all co-pays and deductibles.

_____ _____

Patient/Guardian Signature Date

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Quail Run Physical Therapy Financial Policies

Financial Policy: Patients must recognize that they are responsible for the charges incurred for physical therapy (Workers Compensation excluded, although prior authorization is required).We will submit billing to your insurance, free of charge, for physical therapy services. In the event that your insurance carrier does not submit payment for services rendered, a statement will be issued to you.

Lieu of Personal Injury Policy: If you are involved in a motor vehicle accident we will submit billing to your insurance. A lien of personal injury must be signed. A good faith payment must be paid at each visit or payment arrangements can be made prior to treatment. Any applicable co-payments will be accepted as a good faith payment.

Attorney Lien Policy: If you sustained a personal injury and retained an attorney, our office must receive a signed lien by patient attorney by the 3rd visit or you will be charged for each visit thereafter until a signed lien is received.

Attendance Policy: We do charge $35 for cancelled appointments with less than a 24 hour notice and missed appointments.

Attendance Policy

Physical therapy services are unique in that most patients are scheduled to attend on a frequent basis, commonly 2-3 times per week. Your doctor and therapist will make recommendations for frequency (how often) and duration (how long) you may require treatment. Consideration will be given if your insurance plan has restrictions on the number of visits allowed or requires pre-authorization. We recommend that you attend your sessions regularly for optimal benefit.

Our office hours are 9am to 6pm Monday, Tuesday, and Thursday and Wednesday from 8am to 5pm. With exception to a holiday week or short week, we may then open up on a Friday. You will be informed if you happen to have a scheduled appointment on a Friday.

_____ **Cancellations:**
Initial Please call our office 707-263-6845 as soon as you are aware that you will be unable to attend your appointment. A 24-hour notice is customary. During non-business hours, please leave a message on our answering machine, clearly state your name, time and date of your appointment and reason. If you find it necessary to cancel more than three sessions with less than a 24-hour notice, your therapist will be notified and further scheduling will be at his or her discretion. Repeated cancellations may affect your treatment outcome and are discouraged.

_____ **No Show:**
Initial If you do not show for your scheduled appointment and have not called in to cancel, you will be marked as a no show. We understand that emergencies do occur and something may prevent you from calling to cancel your appointment. However we have a policy that states if you have two No-show appointments, your therapist may notify your doctor and we will remove your name from any remaining appointments you may have rescheduled. Anymore scheduled appointments thereafter will be up the discretion of your doctor and therapist.

_____ **Late Arrival:**
Initial Appointments are scheduled on the hour and half hour. We try as much as possible to stay on time for your appointments. Late arrival (greater than fifteen minutes) may require re-scheduling if your therapist believes that your treatment will be insufficient in the remaining time period. If possible please call 707-263-6845 to let us know that you will be late.

FOTO Patient Intake Form
Hip, Pelvis, Upper Leg

STAFF TO COMPLETE THIS SECTION

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____ / ____ / ____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Date of Survey: ____ / ____ / ____

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, because of your affected hip/pelvis/upper leg, do you or would you have any difficulty...	Extreme difficulty / Unable to do	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. With any of your usual work, housework, or school activities?					
2. Walking between rooms?					
3. Squatting?					
4. Performing light activities around your home?					
5. Performing heavy activities around your home?					
6. Walking two blocks?					
7. Getting up or down 10 stairs (about 1 flight of stairs)?					
8. Standing for 1 hour?					
9. Running on uneven ground?					
10. Hopping?					

11. Rate the level of pain you have had in the last 24 hours *(please circle response)*:

0 1 2 3 4 5 6 7 8 9 10
(None) (Pain as bad as it can be)

12. Please indicate the number of surgeries for your primary condition. ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

13. How many days ago did the condition begin? ☐ 0-7 days ☐ 8-14 ☐ 15-21 ☐ 22-90 ☐ 91 days to 6 mos. ☐ Over 6 mos. ago

14. Are you taking prescription medication for this condition? ☐ Yes ☐ No

15. Have you received treatments for this condition before? ☐ Yes ☐ No

16. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times a week ☐ Once or twice per week ☐ Seldom or never

Patient Name: _____ Patient ID _____

17. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer

18. Height: _____ ft. _____ in. Weight: _____ lbs.

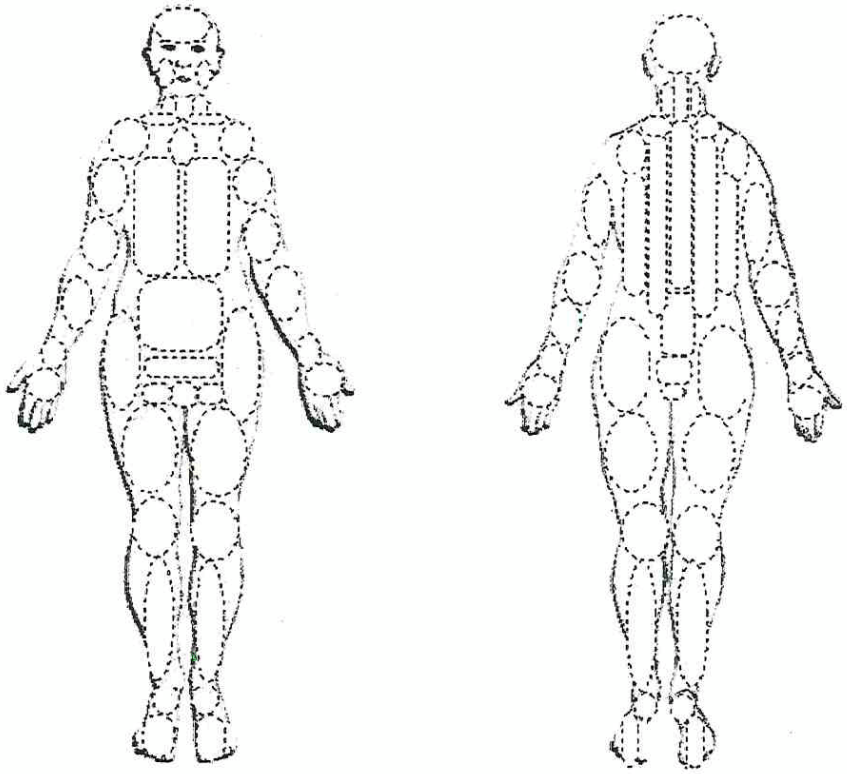
19. This is a statement other patients have made.
"I should not do physical activities which (might) make my pain worse."
Please rate your level of agreement with this statement.

- ☐ Completely Disagree
- ☐ Somewhat Disagree
- ☐ Unsure
- ☐ Somewhat Agree
- ☐ Completely Agree

PQRS Measure 131, Pain Assessment

Patient ID #:	Survey Date: _____ / _____ / _____

Please mark all of the areas where you are experiencing pain on the body part diagram below:



Please review all the qualities in the list below that describe your pain and circle the intensity for each one selected:

Throbbing	Severe	Moderate	Mild
Shooting	Severe	Moderate	Mild
Stabbing	Severe	Moderate	Mild
Sharp	Severe	Moderate	Mild
Cramping	Severe	Moderate	Mild
Gnawing	Severe	Moderate	Mild
Hot / Burning	Severe	Moderate	Mild
Aching	Severe	Moderate	Mild
Heavy	Severe	Moderate	Mild
Tender	Severe	Moderate	Mild
Splitting	Severe	Moderate	Mild
Tiring / Exhausting	Severe	Moderate	Mild
Sickening	Severe	Moderate	Mild
Fearful	Severe	Moderate	Mild
Punishing / Cruel	Severe	Moderate	Mild

PQRI Measure 154, Falls: Risk Assessment

Patient ID: _____ Survey Date: _____

1. Have you fallen in the last year? ____ Yes ____ No

2. Did you sustain an injury from the fall? ____ Yes ____ No

3. Have you fallen 2 or more times in the past year? ____ Yes ____ No

If you answered NO to Question #2 and #3, you do not need to complete the remainder of the questions.

If you answered YES to Question #2 or #3, please complete #4 - #7.

4. Do you have any of the following in your home? Please select all that apply:
   - ____ Clutter where you walk
   - ____ Exposed electrical cords
   - ____ Furniture or other sharp edged items in the normal pathways through your house
   - ____ Poor lighting
   - ____ Raised doorway thresholds
   - ____ Slippery floors
   - ____ Steps and stairways
   - ____ Throw rugs

5. How many medications do you currently take?
   - ____ None
   - ____ 1
   - ____ 2
   - ____ 3 or 4
   - ____ 5 or more

6. Were you taking any of the following medications at the time of your fall(s)? Please select all that apply.
   - ____ Any central nervous system / psychotropic medications
   - ____ Sedative / hypnotics (sleeping medications)
   - ____ Antidepressants (especially tricyclics)
   - ____ Antipsychotics / neuroleptics
   - ____ Benzodiazapines ("nerve pills")
   - ____ Cardiovascular drugs
   - ____ Diuretics
   - ____ Antiarythmics
   - ____ Cardiac glycosides
   - ____ Diabetes medication

7. If you were taking any of the above at the time of your fall(s), are you still taking the medications?
   - ____ Yes
   - ____ No

ABBREVIATED ABC SCALE

Patient Name: _____

How confident are you that you will not lose your balance or become unsteady when you:		No Confidence 0	10	20	30	40	Somewhat Confident 50	60	70	80	90	Completely Confident 100
1.	stand on tip toes and reach for something above your head?											
2.	stand on a chair and reach for something above your head?											
3.	are bumped into by people as you walk through the mall?											
4.	step onto or off an escalator while you are holding onto a railing?											
5.	step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing?											
6.	walk outside on icy sidewalks?											