



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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Home Phone: () -	Cell/Work Phone: () -	Spouse:	

WORK INFORMATION

Employer:	Work Phone () -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> 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	JOINT CONDITIONS		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE		YES	NO	OTHER CONDITIONS		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION		YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (presently or history of)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS		YES	NO	Other: _____			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS		
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs	a Day 1-
<input type="checkbox"/> 2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks	a Week 3-
<input type="checkbox"/> 4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups	a Week 5+
<input type="checkbox"/> x Week	<input type="checkbox"/> 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): _____

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: _____

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Physical Therapy

Treating our patients the way we want to be treated

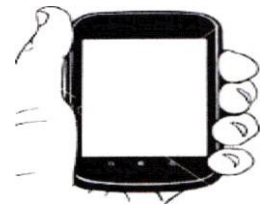
Message Content

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.



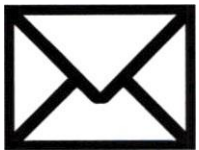
Voice Mail

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 you to receive appointment confirmations by text 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.

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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 that occur one workday prior to the scheduled appointment are subject to a cancellation fee of \$50.00. This fee may be waived if the appointment is rescheduled to a later time the same day or within the same week.
- 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 non-compliance 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.

The following does not apply to Workers' Compensation Clients:

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.

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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 signing 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 hours 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