GOLDEN BEAR
PHYSICAL THERAPY
SPORTS INJURY CENTER

Welcome to Golden Bear!

Thank You for choosing Golden Bear Physical Therapy Sports Injury Center. We know you have a choice, thank you for choosing Golden Bear. Below you will find information regarding your appointment. We request that you print and fill out your paperwork prior to arrival of your appointment. If you are unable to fill out in advance, please arrive to your appointment 30 minutes early.

What you will need to bring to your initial evaluation:

1. Insurance card (*not necessary for workers comp*)

2. Picture ID

3. Referral from physician (*not necessary for Golden Valley Health Center Patients*)

Please bring any x-rays, MRI and or any additional imaging to your appointment for the Physical Therapist.

Appointment Date:	
Appointment Time:	
Physical Therapist:	
Location:	
Telephone Number:	

You will also receive a reminder 24 hours prior to your appointment

If you have any questions, please call the number listed above or reply to this email.

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Patient Consent Form

TREATMENT CONSENT

I understand that I have the right to choose my physical therapy provider and have chosen Golden Bear Physical Therapy and hereby authorize and give my consent to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Treatment of a minor: As a parent and/or legal guardian, I authorize and give my consent for Golden Bear Physical Therapy to treat

_____ (minor's name) while I am not present.

PATIENT INFORMATION CONSENT

I have read and fully understand Golden Bear Physical Therapy's Notice of Information Practices. I understand that Golden Bear may use or disclose my personal health information for the purpose of carrying out my 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 by notifying the practice. I also understand that Golden Bear will consider requests for restrictions on a case by case basis but does not have to agree to request restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Golden Bear'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.

CONFIDENTIAL MEDICAL INFORMATION CONSENT

I hereby authorize Golden Bear to share any and all of my medical/billing information with the following people:

Full Name:	Relationship:
Full Name:	Relationship:

PATIENT AUTHORIZATION

- By my signature - I have read, understand, agree and consent to the above.

Patient Signature:	**Date:**
Parent/Guardian/Guarantor:	**Date:**

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Financial and Attendance Policies

FINANCIAL POLICY

As a courtesy to you, Golden Bear will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Golden Bear is not responsible for issues between the patient and the insurance carrier, nor can Golden Bear intervene or negotiate for either party on disputed claims. Please advise us immediately if you change your insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, Golden Bear requires payment by the patient for any equipment/supply at the time the order is placed. Golden Bear will provide a receipt as documentation of the purchase so you may pursue reimbursement personally.

- I hereby assign payment of benefits by my insurance company to Golden Bear, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance will result in all changes be transferred to my personal balance on my statement.
- I hereby agree to pay any office visit/co-payment at time of visit.
- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

ATTENDANCE POLICY

Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require a 24 hour notice of cancellation. There is a $25.00 charge for cancellation of a follow up appointment without prior notice or not showing for your appointment. This charge is not covered by your insurance, and you are required to pay this fee personally.

No Show Appointment: Is when a person does not show up to their scheduled appointment and does not call to give a reason for canceling. Patient will be taken off the schedule and referred to referring physician without warning if they have 2 no show appointments following their first Initial Evaluation.

Cancellation: We have the right to take a patient off the schedule at any time during their treatment and refer them back to the referring physician if they have a combination of 3 or more cancellations and no shows.

I have read, agree, and understand the above policy.

Patient Signature:	Date:
Parent/Guardian/Guarantor:	Date:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated.

Health care options: Your health information is used as necessary to support the day to day activities and management of Golden Bear Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Information about treatments: Your health information may be used to send you information that you find interesting on the treatment and management of your condition.

□ Please do not use my information for fundraising purposes.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. *These include*:

- The right to request restrictions on the use of your protected health information.
- The right to receive confidential communications regarding your medical condition and treatment.
- The right to inspect your protected health information.
- The right to amend or submit corrections to your protected health information
- The right to receive a printed copy of this notice.

Golden Bear Physical Therapy Duties: We are required by law to maintain the privacy of your protected health information and provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our private policies and practices. These changes in our policies and practices may be required changes by federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain, as permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist. Your request will be reviewed and will generally be approved unless there are legal medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Brandon Nan. PT, DPT Vice President of Operations – 4318 Spyres Way, Modesto, CA 95356, or you may call 209-576-0710 or send an email to bnan@goldenbearpt.com

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint

This notice is effective on or after

Patient Signature:	Date:

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Patient Name:	Date of Birth: Age:
Address:	Social Security Number:
City:	Marital Status: Married Single Widow Gender: ☐ Male Female ☐
State:	Emergency Contact:
Zip Code:	Telephone number of Contact:
Primary Telephone:	Relationship to Contact:
Secondary Telephone:	Employer:
Email Address:	Employment Status:
How did you hear about us?	Referring Doctor:

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other ☐ ☐ ☐ ☐

SECONDARY INSURANCE (if applicable)

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other ☐ ☐ ☐ ☐

WORKERS COMPENSATION (if work related)

Insurance Name:	Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

AUTO INSURANCE (if auto related)

Insurance Name:	Insured/Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

GOLDEN BEAR PHYSICAL THERAPY
SPORTS INJURY CENTER

SUBJECTIVE HISTORY WORKSHEET

Patient Name:	Todays Date:

Describe the present symptoms that brought you here _____

Date symptoms started _____

Was this a result of	☐ Sport Injury ☐ Work Injury ☐ Car Accident ☐ Gradual ☐ Sudden ☐ Sudden ☐ Unknown ☐ Other
Are your symptoms	☐ Improving ☐ Worsening ☐ Staying the Same
Have you had these symptoms before?	☐ Yes if yes, describe _____ ☐ No
If you received treatment in the past for the same or similar symptoms, *who did you see?*	☐ Physical Therapist ☐ Chiropractor ☐ Specialist If yes, was it beneficial? ☐ Yes ☐ No
Indicate what tests have you had	☐ X-Ray ☐ MRI ☐ EMG ☐ Nerve Conduction ☐ other

Pain level ranges: (please circle for each level)

(0=No Pain, 10=Unbearable)										
Presently:	1	2	3	4	5	6	7	8	9	10
At Best:	1	2	3	4	5	6	7	8	9	10
At Worst:	1	2	3	4	5	6	7	8	9	10

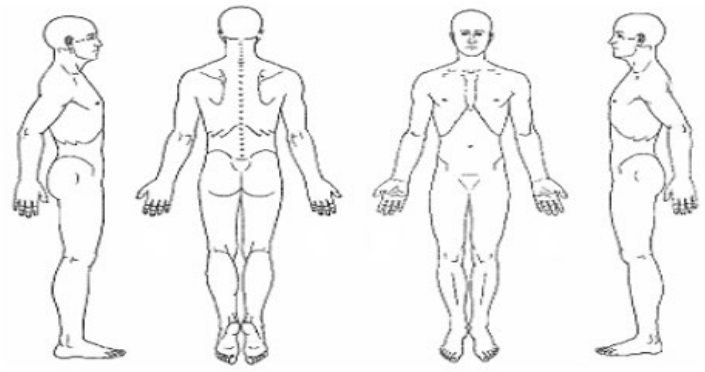
How often do you experience your symptoms?

☐ Constant	76-100% of the day
☐ Frequent	51-75% of the day
☐ Intermittent	26-50% of the day
☐ Occasional	0-25% of the day

Check the boxes that best describes your symptoms

☐ Dull	☐ Ache
☐ Deep	☐ Superficial
☐ Sharp	☐ Burning
☐ Burning	☐ Shooting
☐ Stabbing	☐ Radiating
☐ Numb	☐ Tingling
☐ Pins and Needles	

Place X's on the body chart, the location of your symptoms



What specific movements, positions, or activities, including time of day, makes your symptoms worse?

_____

What actions, positions, topical agents (heat, ice), or types of medication makes your symptoms better?

_____

Do you have any difficulty falling asleep due to your symptoms?	☐ Yes ☐ No
Are you awakened from sleeping, due to pain? *If yes, how many times per night?*	☐ Yes ☐ No ☐ 1-2 ☐ 3-4 ☐ 5+

What activities are you having difficulty performing? (check all that apply)

☐ Standing	☐ Walking	☐ Stairs	☐ Squatting	☐ Kneeling
☐ Driving	☐ Sitting	☐ Lifting	☐ Bending	☐ Holding/carrying objects
☐ Reaching	☐ Gripping	☐ Work Tasks	☐ Keyboarding	☐ Dressing/Grooming
☐ Housework	☐ Gardening	☐ Large Animal Care	☐ Sports	☐ Recreational Activities

Occupation: _____

Presently working?	☐ Yes ☐ No	If yes, ☐ Full Duty ☐ Modified Duty ☐ Restrictions: _____

Job Duties: (check all that apply)

☐ Sitting	☐ Computer work	☐ Bending	☐ Lifting	☐ Standing
☐ Walking	☐ Stairs/Ladders	☐ Crawling	☐ Twisting	☐ Pushing/Pulling
☐ Reaching	☐ Gripping	☐ other		

Living Arrangements	☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other
Does your home have stairs?	☐ Yes ☐ No If yes, how many?
Exercise on a regular basis?	☐ Yes ☐ No
Have you had any falls in the past 12 months?	☐ Yes ☐ No If yes, how many?
Do you smoke?	☐ Yes ☐ No If yes, how many packs per day/week?
If female, are you currently pregnant?	☐ Yes ☐ No If yes, how many weeks?

List all medications that you are currently taking. or ☐ *see attached list*

Have you been diagnosed with, or been told that you have: (check all that apply)

☐ Cancer	☐ Angina/chest pain	☐ Heart Disease	☐ Pacemaker/Defib.	☐ High Blood Pressure
☐ Stroke	☐ Lung Problems	☐ Diabetes I or II	☐ Rheumatoid Arthritis	☐ Seizures/Epilepsy
☐ Anemia	☐ Osteoporosis	☐ Thyroid Problems	☐ Infectious Disease	☐ Mental/Behavioral Disorder
☐ Depression	☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Kidney Disease	☐ Liver/Gall Bladder Condition
☐ Anemia	☐ Colitis/IBS	☐ Head Injury	☐ Parkinson's Disease	☐ Polio
☐ STD	☐ HIV/AIDS	☐ Tuberculosis	☐ Hepatitis A B C	☐ Allergies

List 3 functional activities that you would like to be addressed in therapy, that you are unable or have difficulty in doing, as a result of your problem. *(i.e. be able to wash my hair, be able to prepare/cook a meal without pain, be able to open a jar lid)*

1.
2.
3.

I understand that I have provided accurate and complete information, to the best of my knowledge, of my problem and current status.

Patient Signature:	Date:

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

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