INTAKE FORM

Patient Name(print):

_____

D.O.B:_____**Email :**

Have you recently noted any of the following? ___:Weight Loss/Gain ___:Weakness ___:Nausea/Vomiting ___:Fever/Chills/Sweats ___:Fatigue ___:Numbness/Tingling ___:Pregnancy/IUD ___:Cramps when walking ___:Change in Vision/Hearing ___:Pain at Night ___:Headaches ___:Insomnia

Do you now, or have you ever had any of the following? ___:Surgeries ___:Circulation Problems/Clots ___:Loss of Consciousness ___:Asthma/ Breathing Problems ___:Respiratory Disease ___:Fractures ___:Lung Disease ___:Sprains/ Strains ___:Easy Bruising/Bleeding ___:Diabetes ___:Leg/Ankle Swelling ___:Blood Pressure Problems ___:Urinary Problems/Infections ___:Heart Problems ___:Indigestion/Heartburn ___:Cancer or Tumors ___:Fainting ___:Motor Vehicle Accident ___:Allergies/Skin Sensitivity ___:Stroke ___:Hernia ___:Epilepsy

Please indicate (x) whether you have or had any of the following conditions: ___:Heart Disease or Heart Attack ___:Kidney or Bladder Problems ___:Anemia or other Blood Disorders
Explain and give approximate dates for any items indicated above:

_____

Do you have any surgical implants (metal, plastic, etc...) Yes / No
Explain:_____

_____

Do you have any surgical procedures with approximate

dates:_____

_____

_____ Injury/Condition:_____

Date of Injury/Onset:_____ Type of Surgery:_____ Next Doctor's Appointment:_____ Previous Treatment:_____

_____

Have you ever had any imaging performed? ___:X-Ray ___:Ultrasound ___:Doppler ___:CT Scan ___:MRI Are you pregnant now? Yes / No Are you currently taking any medications? Yes / No Name/Type of medication:_____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other:_____

Rate your pain (average) on a scale of 1 to 10 (1=Light, 10=Severe):_____

What do you hope to get out of your treatment?

_____

_____

What are your physical or fitness GOALS?

Currently:_____

_____

Are you training for a specific sport or event? If so what is your current workout routine?

Are you able/willing to video and record yourself doing specific exercises, movements, with your phone or camera to assess your movement?

Is there anything else you would like to include or ask your physical therapist? _____ _

CONSENT FOR TREATMENT

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by evaluation examination, testing and use of rehabilitative, procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities and accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Because of the nature of services provided, you might be asked to partially disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure. There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform. Consent for Physical Therapy: Knowing that I am suffering from a condition requiring diagnostic or medical treatment, I hereby consent to care by DaraSportsPT as they may deem necessary by their judgment, under
the prescription, if needed, of a licensed physician. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by DaraSortsPT will meet customary standards, I do understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize DaraSportsPT to retain any records for use, for research and for teaching purposes. If I refuse treatment that is suggested for me, I will not hold DaraSportsPT or any individual responsible for any consequences resulting from my decision. I, _____, have had full opportunity to read and consider the contents of this Consent for Treatment. I understand that, by signing this Consent form, I am giving my consent to treatment and attest that I am aware and understand all of the above. Signature: _____Date: _____ If this Consent is signed by a personal representative on behalf of the patient, complete the following: Personal Representative's Name:

_____

Relationship to Patient:

_____

Last Name _____First Name

_____

D.O.B. _____/_____/_____ S.S.# _____-_____-_____
Sex: M / F

Address _____Apt.# _____ City _____ State_____ Zip Code _____

Home (_____)_____Wk (_____)_____ Cell (_____)_____

Email Address

_____

In case of emergency, notify

_____

Ph (_____)_____ Name of Referring M.D. _____ Diagnosis from M.D. _____ Private Insurance Name of Health Insurance: _____ (Anthem, United Health Care, Medicare, etc.) Member Identification Number: _____ Group Number: _____(If applicable) Phone Number for “Eligibility or “Providers”: _____ Name of Secondary or Supplemental Insurance: _____ (If applicable) Member Identification Number: _____ Phone Number for “Eligibility” or “Providers” :_____ Group Number: _____(If applicable)

NOTICE OF PRIVACY PRACTICES Effective April 14, 2003 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 We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations. Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure. Payment includes the disclosure of health information to your insurance company, including Medicare, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary. Health Care Operations included the utilization of your records to monitor the quality of care being given at our facility or for business planning activities. Other special uses Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to send mailings such as a newsletter. Uses and disclosures required by law The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express

yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety, or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes. Your Privacy Rights Restrictions You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request. Confidential Communications You have the right to request confidential communication from us at a location of your choosing. This request must be in writing. Access to PHI You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing. Amendments You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create. Accounting of Disclosures After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization. Complaints If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services. Our Duty to Protect Your Privacy We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us. Privacy Contact If you would like more information about our privacy practices or to file a complaint you may contact: Dara SportsPT, email address darasportsPT@gmail.com. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this, please ask to speak with our Privacy Officer. You signature below is only to acknowledge that you have received this Notice of Privacy Practices: Patient's **Signature_____Date_____ Patient's Name (hand written): _____ Cancellation and No Show Policy You are coming to therapy to remedy the** condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Dara Richman, DPT requires 24 hour advance notice for any cancellation. If you are unable to give 24

hour advance notice or you do not show for your scheduled appointment an administrative fee of $150 will be billed to you. I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to
this policy. _____ **Print name**
_____ _____ **Patient signature Date**

DaraSportsPT
6125 Medau Place
Oakland, CA 94611

darasportspt@gmail.com