



1900 Garden Road, Suite 200 Monterey, CA 93940 PHONE: (831) 250-6770 FAX: (831) 250-6767

Patient Information

(PLEASE PRINT AND FILL OUT ENTIRELY)

TODAYS' DATE _____ PATIENT DATE OF BIRTH _____

PATIENT'S NAME _____
LAST M.I FIRST

SEX: F ___ M ___ PATIENT'S PRIMARY PHYSICIAN: _____

PHONE: () _____ NAME ADDRESS
FAX () _____

OTHER SPECIALTY PHYSICIANS: (please name) _____

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS or FOODS: _____

PLEASE LIST CURRENT MEDICATIONS PATIENT IS TAKING: _____

IS THE PATIENTS IMMUNIZATIONS UP TO DATE (if not EXPLAIN): _____

WHO REFERRED YOU TO THERASENS OCCUPATIONAL THERAPY _____

PARENT'S (1) NAME _____ DOB _____ SS# _____ - _____ - _____
LAST FIRST M.I.

PARENT'S (2) NAME _____ DOB _____ SS# _____ - _____ - _____
LAST FIRST M.I.

PARENT EMAIL ADDRESS _____ CELL/ PHONE () _____ / _____

MAILING ADDRESS _____
STREET/ PO BOX CITY STATE ZIP

EMPLOYER(1) _____ PHONE () _____

BUSINESS ADDRESS _____

PARENT (2) EMPLOYER _____ PHONE () _____

BUSINESS ADDRESS _____

PATIENT INSURANCE: _____



Assumption of Risk & Waiver of Liability

Participant's Name _____

Phone Number _____ Cell Number _____ Work Number _____

Address _____
Street City State Zip

Emergency Contact (other than yourself) _____

Phone Number _____ Cell Number _____ Work Number _____

Address _____
Street City State Zip

I recognize that potentially severe injuries, including but not limited to permanent paralysis or death, can occur in sports or activities involving height or motion, including but not limited to gymnastics, tumbling, trampoline, stairs, dance, rock climbing, swinging and running. Being fully aware of these dangers, I voluntarily consent to the aforementioned person(s) participating in any and all Therasens, Inc. programs and activities, and I KNOWINGLY ACCEPT FULL RESPONSIBILITY AND ASSUME ALL RISKS associated with that participation. In consideration for allowing the above mentioned person(s) to obtain Occupational Therapy instruction, I, on my own behalf and the behalf of the above mentioned person(s) and our respective heirs, administrators, executors, and successors, hereby COVENANT NOT TO SUE or TRY TO COLLECT DAMAGES IN ANYWAY and FOREVER RELEASE Natalie Sanders personally and Therasens, Inc., its officers, directors, shareholders, employees, contractors, or agents from all liability for any and all damages or injuries suffered by the above mentioned person(s) while under instruction, supervision or control of Therasens, Inc., including without limitation, those damages or injuries resulting from acts of negligence on the part of its officers, directors, shareholders, employees, agents, or Natalie Sanders. I agree to INDEMNIFY AND HOLD such individuals HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of such participation in Therasens Inc. programs and activities and to reimburse them for any such expenses incurred. I expressly acknowledge and agree that this agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. In the event of an emergency, I would like the above mentioned person(s) to be taken to a hospital for medical treatment and I hold Therasens, Inc., Natalie Sanders and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for all possible future medical expenses which may be incurred by my child as a result of any injury sustained while participating in Therasens, Inc. I have read and understand this ASSUMPTION OF RISK, WAIVER OF LIABILITY and MEDICAL AUTHORIZATION and I VOLUNTARILY affix my name in this agreement.

Legal Guardian Signature _____ Date _____



Recognition of TheraSens Policies & Patient Responsibilities

Patient Name: _____ DOB: _____

1. It is the patient/parent(s)/guardian responsibility to inform TheraSens, INC. of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc., as soon as possible. Failure to do this could result in total patient responsibility for charges incurred. _____ Initial
2. It is the patient/parent(s)/guardian responsibility to attain authorization and approval for therapy with insurance companies, including Blue Cross, that TheraSens, INC. does not contract with or is considered out of network. _____ Initial
3. It is the patient/parent(s)/guardian responsibility to understand their own insurance policy regarding their deductibles, co-pay amounts, and number of allied health visits authorized and approved for the year. _____ Initial
4. No-Shows and Cancellations: Appointments are a contract for the exclusive use of the therapist's time. Parents will be charged \$75 for no-shows and late cancellations. Cancellations are late when given less than a 24-hour notice. Termination of services may occur if patients are not consistently attending their scheduled time. Cancellation Policy: We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with consistent attendance. It is also important that you arrive on time so that your child can benefit from a full session. We understand that there will be unavoidable circumstances that may come up. In order for us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. _____ Initial
5. 3. For your convenience, TheraSens, INC. allows parents/legal guardians or caregiver to leave the premises during their child's appointment. However, it is very important to be back on the premises at the end of your child's treatment, so the therapist can discuss treatment with the parent/legal guardian or caregiver and to ensure your child's safety if there is no one that can stay with your child. _____ Initial
6. If TheraSens, INC. notices chronic tardiness in picking up children, we will begin asking the parent/legal guardian or caregiver to stay during the patient's treatment. TheraSens, INC. must have a cell phone number to reach you before leaving. _____ Initial

7. TheraSens, INC. realizes the parent/legal guardian or caregiver's time is important, and it is our sincere intention to honor all appointment times. On occasion, a delay or emergency will occur, and we may need to delay or reschedule the patient's appointment. If this occurs, notification will be given as early as possible. To expedite this process, we ask the parent/legal guardian/caregiver to provide us with a daytime telephone number for notification purposes. ____Initial

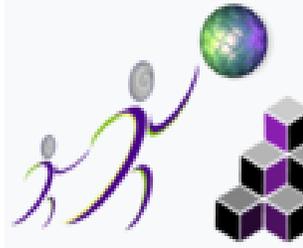
8. Out of pocket Policy: Insurance policies are contracts made between the patient and the insurance company. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. If for any reason treatment is denied by your insurance, we will charge for the usual and customary amount paid by your insurance company. _____Initial

9. Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments and deductible amounts due. Due to company and industry wide standard ethics, we are required to collect all copayments and deductibles that are due by your specific policy. We are obligated to follow these standards. _____Initial

10. Occasionally we have trained volunteers completing their hours for occupational therapy, physical therapy, and other health related science programs. TheraSens, INC. plays an important role in helping students in their professional development. Initialing indicates that you give permission for the volunteers to shadow treatments or assist the therapist as needed when working with your child. Volunteers are screened and are required to abide by HIPPA confidentiality policies. ____Initial

Signature or Legal Guardian

Date



THERASENS, INC.

CONSENT TO TREATMENT

In signing below, I agree to be treated by the staff of Therasens, Inc. as prescribed by my primary care physician and/or referring physician. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Therasens, Inc. and to receive communication via email and/or text.

Patients (Guardian if minor) Signature: _____ Date: _____

CANCELLATION/NO-SHOW POLICY

At Therasens, Inc, we pride ourselves on providing high quality care. In order for us to do this, we ask that you give us a 24-hours notice in advance to cancel and/or reschedule your appointment times. All appointments not kept without at least 24-hour notice are subject to a \$50 fee. No-Show appointments are subject to a \$75 fee and No-Show for an Initial Evaluation is subject to a \$100 fee. Please note Late Cancels and No-Shows are not covered by your insurance. A credit card is required to be kept on file and will be charged accordingly.

Patients (Guardian if minor) Signature: _____ Date: _____

FINANCIAL POLICY

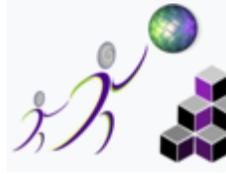
We will courtesy bill your insurance; however, payment is required towards your deductible and/or co-insurance and/or co-pay. I understand that I am responsible for understanding my health insurance benefits and determining if my insurance benefits and insurance policy covers the services provided by Therasens, Inc. I hereby authorize Therasens, Inc to release necessary information to process my claims. I understand that I am financially responsible for all non-covered services. I am aware there is a \$35 fee for any returned checks. I am also aware that there is a 5% charge if using a credit card.

Patients (Guardian if minor) Signature: _____ Date: _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read and fully understand Therasens, Inc.'s Notice of Privacy Practices. I understand that Therasens, Inc. may use or disclose my personal health information for all 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 Therasens, Inc. will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restriction.

Patients (Guardian if minor) Signature: _____ Date: _____



CREDIT CARD INFORMATION TO BE KEPT ON FILE

Name on card: _____

Credit Card Number: _____

Expiration Date: _____ CVV Security Code: _____

Zip Code: _____

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding the debt to a consumer credit reporting agency, the debt shall be void and unenforceable.



HIIPPA NOTICE & PRIVATE PRACTICES 2026

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care or payment for your care
- Share information in a disaster relief situation
- Include information for us electronically
- Include your information in *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to treatments
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will not share your mental health treatment records without your written consent unless it is for treatment or another law requires us to share the information.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.