ASCEND
Physical Therapy & Balance Center

*** For Existing/ Previous Patients Only:
□ I acknowledge that all personal information is the same and have no further changes necessary. **Signature:** _____

PATIENT INFORMATION

NAME	GENDER ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH

ADDRESS

CITY | STATE | ZIP CODE

BILLING ADDRESS (if different from above)

CONTACT: Please check the number you prefer to be called at

☐ HOME ( ) _____ ☐ WORK ( ) _____

☐ CELL ( ) _____ ☐ EMAIL: _____

☐ I prefer appointment reminders be sent to my email

REFERRING DOCTOR

Name of Doctor who referred you: _____ Date of follow up visit with this Doctor: _____

This date is needed to send a progress report before your appointment

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT
PHONE ( )	ALTERNATE ( )

WORKERS COMPENSATION / ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO	WERE YOU INJURED ON THE JOB ☐ YES ☐ NO	DATE OF INJURY/ACCIDENT	CLAIM NUMBER

NAME OF INSURANCE CARRIER	PHONE ( )	FAX ( )
CLAIMS ADJUSTER	PHONE ( )	FAX ( )
NURSE CASE MANAGER	PHONE ( )	FAX ( )

HOW DID YOU HEAR ABOUT ASCEND PHYSICAL THERAPY?

PLEASE SELECT ALL THAT APPLY:

☐ DOCTOR: _____ ☐ INSURANCE: _____

☐ FAMILY or FRIEND: _____ ☐ INTERNET OR YELP: _____

☐ OTHER: _____

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NOTICE OF PRIVACY PRACTICES

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

SUMMARY:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells how you can obtain access to this information.

As a patient, you have the following rights.

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that you medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. A complete copy of our privacy practices is available at any time in our waiting room or upon request. If you have any questions about this notice please contact the following Privacy Officer.

Effective Date of this Notice: 01/01/2021
Contact Person: Joseph Park—Privacy Officer
12465 Lewis Street. Suite 101 Garden Grove, CA 92840
(714) 703-8477 Email: Joe@ascendpt.net

I, _____hereby acknowledge that I have had the opportunity to review a copy of this practice's *NOTICE OF PRIVACY PRACTICES*. I understand that if I have questions or complaints regarding my privacy rights that I may contact the privacy officer. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way during my course of treatment.

Patient's Signature: _____ **Date:** _____

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LATE CANCELLATION OR NO SHOW POLICY

A 24-hour notice is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

In an instance of a cancellation without 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge a $40 fee.

If there's an emergency, we understand and can make an exception. More than 3 late occurrences, late cancellations or no shows will result in day-to day call in basis in order to schedule appointments. We reserve the right to discontinue care due to non-compliance.

Patient's Signature: _____ **Date:** _____

CONSENT TO TREATMENT

I hereby consent to the therapeutic procedures outlined below, to be performed by Ascend Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Ascend Physical Therapy, Inc. or from any other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature: _____ **Date:** _____

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ASCEND PHYSICALTHERAPY PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of a person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4**:** **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil a cation, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physical therapist within 30 days of sig nature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services. _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ By: _____ _____
Physical Therapist or Authorized Representative's Signature Date Patient's or Patient Representative's Signature Date

Ascend Physical Therapy By: _____
Print or Stamp Name of Physical Therapist, Medical Group or Association. If Representative, Print Name and Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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Vestibular Patient History

Name:			Date:	
Date of Birth:	Age:	Height:	Weight:	Next Doctors Visit:
Occupation:			Have you been a patient here before?	

What brings you to physical therapy?	
Current Problem/Symptoms	When did the problem start?
1.	
2.	

Please list your goals in coming to physical therapy.
1.
2.
3.

Please indicate if you have had or have any of the following conditions.

Please check (✓) any of the following that apply to you:

- □ History of Cancer
- □ Heart disease
- □ High/Low blood pressure
- □ Angina / Chest pain
- □ Shortness of breath
- □ Stroke / TIA
- □ Osteoporosis
- □ Osteoarthritis
- □ Rheumatoid arthritis
- □ Joint replacement
- □ Recent excessive weight loss
- □ Changes in appetite
- □ Lightheadedness/Dizziness
- □ Frequent loss of balance
- □ Falls
- □ Anxiety / Stress
- □ Depression
- □ Fibromyalgia
- □ Obesity
- □ TBI/History of Concussions
- □ Pacemaker
- □ Diabetes I or II
- □ Allergies/Asthma
- □ Memory Loss
- □ Headaches / Migraines
- □ Hernia
- □ Nausea or vomiting
- □ Bowel or bladder problems
- □ HIV - positive / AIDS/Hepatitis
- □ Dementia/Alzheimer's Disease
- □ Pregnant (currently)
- □ Seizures
- □ Fainting
- □ Difficulty sleeping
- □ Smoking tobacco
- □ Vision (glasses / contacts)
- □ Hard of hearing / hearing aid
- □ Lupus
- □ Parkinson's/Huntington's
- □ Alcoholism

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Name:	Date:

Please list any other medical conditions, surgeries, or health concerns not listed above.	
Condition/Surgery	Date
Which diagnostic tests have you had? (please circle all that apply) *X-Ray MRI CT scan VNG Blood Work PET scan EMG EEG Other:*	

MEDICATIONS				
Name	Dosage	Frequency	**Administration Route** (ex: oral, injection, etc.)	What is it for?

I certify that the foregoing statements are true to the best of my knowledge and belief.

Patient's Signature: _____ **Date:** _____

Reviewed by Therapist: _____ **Date:** _____

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Dizziness Handicap Inventory

Patient Name: _____ Date: _____

Please check "Yes", "Sometimes", or "No" to each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.	Yes	Some-times	No
1. Does looking up increase your problem?			
2. Because of your problem, do you feel frustrated?			
3. Because of your problem, do you restrict your travel for business or recreation?			
4. Does walking down the aisle of a supermarket increase your problem?			
5. Because of your problem, do you have difficulty getting into or out of bed?			
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?			
7. Because of your problem, do you have difficulty reading?			
8. Does performing more ambitious activities like sports or dancing or household chores such as sweeping or putting the dishes away increase the problem?			
9. Because of your problem, are you afraid of leaving your home without someone accompanying you?			
10. Because of your problem, are you embarrassed in front of others?			
11. Do quick movements of your head increase your problem?			
12. Because of your problem, do you avoid heights?			
13. Does turning over in bed increase your problem?			
14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?			
15. Because of your problem, are you afraid people may think you are intoxicated?			
16. Because of your problem, is it difficult for you to go for a walk by yourself?			
17. Does walking down a sidewalk increase your problem?			
18. Because of your problem, is it difficult for you to concentrate?			
19. Because of your problem, is it difficult for you to walk around your house in the dark?			
20. Because of your problem, are you afraid to stay at home?			
21. Because of your problem, do you feel handicapped?			
22. Has your problem placed stress on your relationships with your family or friends?			
23. Because of your problem, are you depressed?			
24. Does your problem interfere with your job or household responsibilities?			
25. Does bending over increase your problem?			

Instructions: Put a check in the box that best describes you:

☐Negligible symptoms	☐Performs usual work duties but symptoms interfere with outside activities	☐Currently on medical leave or had to change jobs because of symptoms
☐Bothersome symptoms	☐Symptoms disrupt performance of both usual work duties and outside activities	☐Unable to work for over one year or established permanent disability with compensation payments