



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 <input type="checkbox"/> MALE <input type="checkbox"/> 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				
<input type="checkbox"/> HOME () _____		<input type="checkbox"/> WORK () _____		
<input type="checkbox"/> CELL () _____		<input type="checkbox"/> EMAIL: _____		
<input type="checkbox"/> 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: _____				
<i>This date is needed to send a progress report before your appointment</i>				

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT
PHONE ()	ALTERNATE ()

WORKERS COMPENSATION / ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE YOU INJURED ON THE JOB <input type="checkbox"/> YES <input type="checkbox"/> 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: _____

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 your 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:** _____

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:** _____



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 action, 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 signature. 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 YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

By: _____
Patient's or Patient Representative's Signature Date

Ascend Physical Therapy
Print or Stamp Name of Physical Therapist, Medical Group or Association.

By: _____
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.

FACIAL NERVE PARALYSIS PATIENT INTAKE QUESTIONNAIRE

Patient Name: _____ **Age:** _____ **Date:** ____/____/____

Diagnosis or Cause of Facial Paralysis: Bell's palsy Acoustic Neuroma Ramsay Hunt Trauma Other

Side of Involvement: Right Left Both **Onset / Surgery:** _____

Occupation / Hobbies: _____

Initial Involvement:

- Onset was: sudden gradual
 I lost: all movement partial movement

Recovery Process:

- I began to see movement return _____ weeks / months later

Relevant Past Medical History (check all that apply):

Special Tests	Previous Treatment
<input type="checkbox"/> MRI / MRA <input type="checkbox"/> Blood tests <input type="checkbox"/> CT scan <input type="checkbox"/> Evoked electromyography (EMG) <input type="checkbox"/> Hearing test	<input type="checkbox"/> initially had antivirals / steroids <input type="checkbox"/> physical therapy <input type="checkbox"/> electrical stimulation <input type="checkbox"/> acupuncture <input type="checkbox"/> psychologist <input type="checkbox"/> psychiatrist <input type="checkbox"/> Botox Date of last Botox injection: _____ <input type="checkbox"/> Plastic surgery

Functional Complaints (check all that apply):

<input type="checkbox"/> Pain/tightness (if so, where?)	
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Excessive tearing	<input type="checkbox"/> Imbalance
<input type="checkbox"/> Difficulty eating/drinking	<input type="checkbox"/> Depressed
<input type="checkbox"/> Difficulty with speech/communication	<input type="checkbox"/> Altered feeling/sensation
<input type="checkbox"/> Headaches	<input type="checkbox"/> Altered taste
<input type="checkbox"/> Headaches	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Difficulty performing job/hobbies	<input type="checkbox"/> Avoiding social settings

Please list your goals:

1. _____
2. _____
3. _____
4. _____

How much caffeine (coffee, soda, iced tea, chocolate) **do you consume per day?** _____

Do you smoke? NO YES

Do you consume alcohol? NO YES

Please list all SURGERIES and dates: *(continue on back of page if necessary)*

Surgery	Date

Please list all SERIOUS ILLNESSES and dates: *(continue on back of page if necessary)*

Illness	Date

List your CURRENT MEDICATIONS (including over the counter, vitamins and herbs): See attached list

Medication/Vitamin/Herb	Dose	Frequency	Administration Route <small>(for example: by mouth, injection, etc.)</small>

PHYSICIAN INFORMATION: *List all doctors you would like to receive a copy of your physical therapy evaluation.*

Neurologist/ENT/Cardiologist/Gerontologist/Osteopath

Address/Phone/Fax

Specialty

Referring MD:		
Primary Care MD:		
Others MDs:		

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

Signature of Patient

Date

Reviewed by Physical Therapist

Date



ASCEND

Physical Therapy & Balance Center

FACIAL DISABILITY INDEX

Patient Name: _____

Date: ____ \ ____ \ ____

Please circle the most appropriate response to the following questions related to problems with the function of your facial muscles. For each question, consider your function **during the past month**.

1. How much difficulty did you have keeping food in your mouth, moving food around in your mouth, or getting food stuck in your cheek while eating?

Usually did with:

- 5 - no difficulty
- 4 - a little difficulty
- 3 - some difficulty
- 2 - much difficulty

Usually did not eat because:

- 1 - of health
- 0 - of other reasons

2. How much difficulty do you have drinking from a cup?

Usually did with:

- 5 - no difficulty
- 4 - a little difficulty
- 3 - some difficulty
- 2 - much difficulty

Usually did not eat because:

- 1 - of health
- 0 - of other reasons

3. How much difficulty did you have saying specific sounds while speaking?

Usually did with:

- 5 - no difficulty
- 4 - a little difficulty
- 3 - some difficulty
- 2 - much difficulty

Usually did not drink because:

- 1 - of health
- 0 - of other reasons

4. How much difficulty did you have with your eye tearing excessively or becoming dry?

Usually did with:

- 5 - no difficulty
- 4 - a little difficulty
- 3 - some difficulty
- 2 - much difficulty

Usually did not speak because:

- 1 - of health
- 0 - of other reasons

5. How much difficulty did you have with brushing your teeth or rinsing your mouth?

Usually did with:

- 5 - no difficulty
- 4 - a little difficulty
- 3 - some difficulty
- 2 - much difficulty

Usually did not tearing because:

- 1 - of health
- 0 - of other reasons

6. How much of the time have you felt calm and peaceful?

- 6 - all of the time
- 4 - a good bit of the time
- 2 - a little of the time

- 5 - most of the time
- 3 - some of the time
- 1 - none of the time

7. How much of the time did you isolate yourself from people around you?

- 1 - all of the time
- 3 - a good bit of the time
- 5 - a little of the time

- 2 - most of the time
- 4 - some of the time
- 6 - none of the time

8. How much of the time have did you get irritable toward those around you?

- 1 - all of the time
- 3 - a good bit of the time
- 5 - a little of the time

- 2 - most of the time
- 4 - some of the time
- 6 - none of the time

9. How often did you wake up early or wake up several times during your nighttime sleep?

- 1 - every night
- 3 - a good number of nights
- 5 - a few nights

- 2 - most nights
- 4 - some nights
- 6 - no nights

10. How often has your facial function kept you from going out to eat shop or participate in family or social events?

- 1 - all of the time
- 3 - a good bit of the time
- 5 - a little of the time

- 2 - most of the time
- 4 - some of the time
- 6 - none of the time

Scoring: Physical Function: $\frac{\text{Total Score (questions 1-5)} - N \times 100}{4}$

Social Function: $\frac{\text{Total Score (questions 6-10)} - N \times 100}{5}$

SYNKINESIS ASSESSMENT QUESTIONNAIRE (SAQ)

Patient Name: _____ Date: _____

Instructions: Please answer the following questions regarding facial function, on a scale from 1-5, according to the following scale:

- 1 = seldom or not at all
- 2 = occasionally, or very mildly
- 3 = sometimes, or mildly
- 4 = most of the time, or moderately
- 5 = all the time, or severely

	Question	Score (1-5)
1.	When I smile, my eye closes	
2.	When I speak, my eye closes	
3.	When I whistle or pucker my lips, my eye closes	
4.	When I smile, my neck tightens	
5.	When I close my eyes, my face gets tight	
6.	When I close my eyes, the corner of my mouth moves	
7.	When I close my eyes, my neck tightens	
8.	When I eat, my eye waters	
9.	When I move my face, my chin develops a dimpled area	
<i>Office use only</i> Sum of Scores 1-9		
<i>Office use only</i> SAQ Total Score		

Summate scores for questions 1-9 /45 x 100 = SAQ Total Score