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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Orthopedics 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

Garden Grove: 12465 Lewis St. #101 Garden Grove, CA 92840 | P: 714-703-8477 | F: 714-703-8157
Buena Park: 5832 Beach Blvd. #114 Buena Park, CA 90621 | P: 714-707-2699 | F: 714-784-2160
Laguna Woods: 24361 El Toro Rd., #140 Laguna Woods, CA 92637 | P: 949-694-9988 | F: 949-694-9977

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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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