1520 Brookhollow Dr, Suite 37
Santa Ana, CA 92705
T: (714) 953-7330
F: (949) 727-2193

401 N Brookhurst St, Suite 100
Anaheim, CA 92801
T: (714) 563-2318
F: (949) 727-2193

www.sevento7pt.com
Sevento7pt@gmail.com

History and Physical Condition Information

Last Name	First Name	Middle	Date of Birth	Age	Gender

Mailing Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Email Address

Emergency Contact	Relationship	Daytime Phone	Cell Phone

Occupation / Job	Date of Injury	Date of Surgery	What happened?

Appointment Reminder: [ ] Text [ ] Voice [ ] E-mail

Do you now have / or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Allergies			Headaches			Seizures		
Arthritis			Heart Disease / Attack			Short of Breath (SOB)		
Asthma			Hepatitis			Sleeping Problems		
Balance Problems			High Blood Pressure			Speech Problems		
Cancer			Metal Implants			Strokes		
Cardiovascular Disease			Multiple Sclerosis			Tuberculosis		
Currently Pregnant			Osteopenia/Osteoporosis			Other		
Diabetes			Parkinson's					
General Weakness			Recent Hospitalization					

Please Rate the level of your pain: **(Mild)** 1 2 3 4 5 6 7 8 9 10 **(Extreme)**

Describe your Pain: [ ]Sharp [ ]Aching [ ]Constant [ ]Radiating [ ]Tingling [ ]Numbness

Do you have an advance healthcare directive in place? [ ] Yes [ ] No

If yes, would you like to provide us with a copy? [ ] Yes [ ] No

Do you need more information on advance directives? [ ] Yes [ ] No

Is this injury related to: [ ] Work [ ] Auto Accident [ ] Personal Injury [ ] None

Have you had [ ] Physical Therapy / [ ] Occupational Therapy before?

Have you ever been in a Home Health Care Facility? [ ] Yes / Discharged Date: _____ [ ] No

What is your goal for therapy?: _____

The above information is correct to the best of my knowledge.

Signature: _____ **Date:** _____

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Medication Sheet

Patient's Name: _____ Date: _____

Please List All Current Medications

Name of Medication	Dosage	Route
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies

_____

_____

_____

_____

_____

_____

Office Use Only
Verification Date: _____

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Request/Refusal Form for Interpreting Services

I _____ (Patient's Name) understand my right to receive interpreting services free of charge and acknowledge that I was offered access to these services. Seven to 7 staff also explained that using minors, friends and/or a person that has not been trained as an interpreter is not advisable.

Please **initial** an option below:

[_____] I request interpreting services. Language: _____

[_____] I do not need an interpreter. I am able to speak to the therapist in English.

[_____] I decline interpreting services. I will use a family member or friend to interpret.

[_____] I will rely on office staff to interpret.

Signature of Patient: _____ Date: _____

Signature of Parent: _____ Date: _____
(If Patient is under 18 years of age)

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operation (164.50B (a))

I _____ (Patient's Name) understand that any part of my healthcare, Seven to 7 originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that the information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my health care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Rehab Therapy Team / or Seven to 7 notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I understand that:

- I have the right to review Seven to 7 Notice of Information practices prior to signing this consent
- Seven to 7 reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I have provided if requested
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restriction as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and Seven to 7 is not required by law to agree to the restrictions requested
- I may revoke this consent in writing at any time, except to the extent that Seven to 7 has already taken action in reliance thereon

Assignment of Benefits Release of Information / Treatment Authorization

- I authorize payment of medical benefits to Seven to 7, Inc for any service provided.
- I authorize the release of medical information to be used for the evaluation and payment of claims.
- I authorize Seven to 7, Inc to perform the treatment and/or procedures ordered by the physician. I acknowledge that no guarantees either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures.
- I authorize the receipt of patient rights and responsibilities and the privacy policy.
- I confirm that there is a $50 dollar charge for any cancellation made with less than 24-hour notice.
- I understand that if I no show two appointments I will be discharged from physical/occupational therapy.

Signature of Patient / Legal Guardian: _____ Date: _____

Printed Name of Patient / Legal Guardian: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I, the undersigned, authorize the release of healthcare information regarding my treatment here at Seven to 7 Physical & Hand Therapy to the following person(s):

(PLEASE INDICATE PERSON YOU AUTHORIZE BELOW OR INITIAL "DOES NOT APPLY")

DOES NOT APPLY _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This Request and authorization applies to (check at least one):

[ ] Healthcare information relating to the following treatment, condition, or dates:
_____

_____

[ ] All healthcare information

[ ] Other: _____

_____

Signature of Patient: _____ Date: _____

Guardian Signature: _____ Date: _____
(If Patient is under 18 years of age)

THIS AUTHORIZATION EXPIRES IN ONE YEAR