Central Coast Hand Rehab

Patient Information

Last Name	Middle Initial	First Name	Date of Birth	Sex	Age

Address	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #	Social Security #

Responsible Party	Relationship	Date of Birth

Responsible Party's Address

Employer	Occupation/Student

Emergency Contact	Phone Number

Name of spouse

Who referred you to this office?

Reason for referral	Date current problem began

Is this treatment for an accident ___ yes ___no? If yes the date of injury: _____
How did accident happen? _____
Where did accident occur? _____

Medical History

Diabetes Yes__ No__
Headaches Yes__ No__
Hernia Yes__ No__
Seizures Yes__ No__
Pace Maker Yes__ No__
Allergies Yes__ No__

Metal Implants Yes__ No__
Kidney Problems Yes__ No__
Nervous disorders Yes__ No__
Heart Attack/Disease Yes__ No__
High Blood Pressure Yes__ No__
Previous Surgeries Yes__ No__

List all current medications: _____

_____

Other pertinent medical history: _____

_____

List type and date (Mo/Yr) of pertinent surgeries: _____

_____

List allergies: _____

_____

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

Consent to Treat Form

The patient authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient gives the authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Occupational Therapist. The patient will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.

The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or consent of his /her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if Central Coast Hand Rehab Center, proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I hereby consent to receiving occupational therapy at Central Coast Hand Rehab Center to begin on this date and terminating when determined by myself, my physician or my Occupational Therapist.

I have read (or have had read to me) the above information and understand the content.

Patient/Guardian Signature _____ Date_____

Witness Signature _____ Date_____

Please list an emergency contact, either inside or outside of the home:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

MEDICAL RECORDS RELEASE

I hereby grant Central Coast Hand Rehab my permission to release information as contained in my medical records as may be deemed necessary.

_____
Patient/Guardian signature

_____
Name printed

_____
Date

Central Coast Hand Rehab

Patient:_____

I have received Central Coast Hand Rehab's Notice of Information and Privacy Practices,

Signature: _____
(Patient or Authorized Representative signature)

Date:_____

Relationship to patient:_____
(Applicable only if Authorized Representative signed for patient)

Central Coast Hand Rehab representative witness signature: _____

Date:_____

Central Coast Hand Rehab (CCHR)

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

Understanding your health record/information:

Each time you visit a hospital, physician, or each time a health care professional visits your home a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to you care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your health information rights:

Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to:

. Request in writing a restriction on certain uses and disclosures of your information. CCHR is not required to agree to comply with your requested restriction.

. Request in writing amendments to your health record, either clinical or demographic. . Inspect and request in writing a copy of your health record

. Obtain an accounting of disclosures of your health information

. Request communications of your health information by alternative means or at alternative locations. Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our responsibilities:

Central Coast Hand Rehab is required to maintain the privacy of your health information. In addition, we will: Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you and will abide by the terms of this notice:

. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

. Any new notices will be on file at our office. We reserve the right to change our practices and to make the new provision effective for all protected health information we maintain. Should our information practices change, we will have notices at our office available for you.

For more information or to report a problem:

If you have questions and would like additional information, you may contact our office at (805) 542-0830. If you believe your privacy rights have been violated, you can also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

We will use your health information for treatment. Information obtained by the assessment professional will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, members of your healthcare team will then record the actions they took, their observations and education provided. We will also provide other practitioners involved with your care with copies of various reports that should assist them in treating you as well as enabling your physician to provide orders for your home care.

We will use your health information for payment. Your information will be utilized to obtain payment for services provided. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, services provided and supplies used. Outside collection agencies may also be utilized.

We will use your health information for regular healthcare operations. We may use and disclose health information in order to facilitate operations and as necessary to provide quality care to all patients. Examples include:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs. Protocol development, case management and care coordination. Employee performance and evaluation
- Training programs including those in which students, trainees or practitioners in health care learn under Supervision.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development Patient satisfaction surveys
- In coordination of emergency and disaster planning and implementation

For treatment alternatives: We may use and disclose your health information to tell you about **or** recommend possible treatment options or alternatives that may interest you.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples may include: therapy services, laboratory tests, supply distribution, and audit services. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however we require the Business Associate to appropriately safeguard your information.

Communication with *family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friends or any other person you identify, health information relevant to that person's involvement your care or payment related to your care.

Research: We may disclose information to researchers when a review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide information about your treatment alternatives or other health Related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): As required by law we may disclose to the **FDA** health information relative to adverse events with respect to food, supplements, products and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Practices availability: This notice will be prominently posted in the office. Patient will be provided a hard copy and the notice will be maintained at our office.

Authorization to use or disclose health information: Other than stated in this document, CCHR will not disclose your health information without your written authorization. If you or your representative authorizes CCHR to use or disclose your health information, you may revoke such authorization in writing at any time.

NOTICE OF INFORMATION & PRIVACY PRACTICE