THE CYPRESS CENTER

Innovative physical therapy and wellness

First Name_____ Last Name_____

Date of Birth: _____ Social Security #:_____ Sex: M / F

Email: _____ Referred By: _____

Home Phone: ( ) _____ -_____ Cell Phone: ( ) _____-_____

Work Phone: ( ) _____ -_____

Address_____

City_____ State _____ Zip Code _____

Occupation: _____ Employer: _____

Sports/Activities: _____

Emergency Contact: _____ Phone: ( ) _____-_____

How did you find The Cypress Center?

Physician Referral ☐ Name: _____

Friend/Family Referral: ☐ Name: _____

Internet: ☐ Site: _____

Other: ☐ _____

860 Via De La Paz Suite B-1
Pacific Palisades, CA 90272

P: 310-573-9553 F: 310-573-9533
www.thecypresscenter.com

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Please initial after reading statements:

1. **Consent to Treatment:** I consent to rehabilitation and related services at The Cypress Center, a Physical Therapy Corporation. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and or direct contact of a sensitive nature. _____

2. **Authorization of Payment:** I hereby authorize my insurance carrier(s) to pay The Cypress Center, a Physical Therapy Corporation directly for services rendered. I also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. _____

3. **Cancellation Policy:** I understand that a cancellation must be made at least 24 hours in advance of my scheduled appointment to avoid being charged **a $125 cancellation fee**. _____

4. **Email Patient Reminders and Electronic Health Information:** I understand the risks of unencrypted email and do hereby give permission to *The Cypress Center* to send me personal health information via unencrypted email and/or **patient appointment reminders.** _____

   EMAIL ADDRESS: _____

5. **Treatment of Minor:** I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

   Guarantor Name: _____

   Guarantor DOB: _____

   Address Same as Patient: Y / N

Patient Signature: _____ Date: _____

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THE CYPRESS CENTER INC.

HIPAA

PATIENT CONSENT FORM

Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review out Notice before signing this Consent. The terms of out Notice may change. If we change out Notice, you may obtain a revised copy by contacting or Privacy Officer @ 310-573-9553.

You have the right to request that we restrict how we protect health information about you, is used or disclosed for treatment payment and health care operations. You have the right to revoke this Consent, in a written statement, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Cypress Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The Cypress Center has a Notice of Privacy Practice and the patient has the opportunity to review this Notice.**
- **The Cypress Center reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the uses of their information, but The Cypress Center does not have to agree to those restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures with then cease.**
- **The Cypress Center may condition receipt of treatment upon the execution of this consent.**

This Consent was signed by: _____

Printed Name-Patient or Representative/Relation to Patient

_____/___/_____

Signature Date

Witness/The Cypress Center _____

Printed Name-The Cypress Center

_____/___/_____

Signature Date

THIS FORM IS NOT INTENED FOR USE WITHOUT THE ADVICE OF LEGAL COUNSEL.

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MEDICATIONS

Please list all prescription, over the counter, and herbal medications and supplements

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Name of Medication	Dosage	Frequency	Route (oral, topical, etc.)

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Physical Therapy Screening Questionnaire and Subjective Examination

Name_____ DOB _____ Age_____ Height _____ Weight _____

Date of onset of injury? _____ How did this injury occur? _____

Please describe current complaint_____

Have you fallen in the last year? _____

Are your current symptoms related to a recent fall? _____

Please indicate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain imaginable (please circle) 0 1 2 3 4 5 6 7 8 9 10 Current _____ at best _____ at worst _____

How would you describe your pain (please circle): Dull Shooting Sharp Constant Ache Tingling Burning Numb Discomfort Other_____

What makes your symptoms WORSE? (Please circle)

Bending Driving Lifting Walking Sitting Sports Standing Steps Stairs Working Overhead Reaching Other_____

What makes your symptoms BETTER? (Please circle)

Heat Standing Resting Medication Ice Sitting Walking Working Overhead Reaching Other_____

Have you sought previous treatment for this injury? If so, please describe_____

Please list any Tests/Findings/X-rays/MRI/CT Scan_____

Are you currently working? Y N N/A With Restrictions? Y N N/A

If no, when was the last day of work? _____ Occupation: _____

Do you take your blood pressure regularly? Y N If yes, what was your last reading? _____

Have you had any of the following in the past 2 weeks? Is your MD aware? Yes No

Sleep Disturbance Night Sweats Night Pain Weakness Numbness

Dizziness Tingling Fatigue Headaches Swelling

Nausea Vomiting Fever Double Vision Slurred Speech

Unexplained Weight Loss or Gain Changes in Bowel or Bladder habits

Do you have a history of any of the following?

Y N High Blood Pressure Y N Osteoporosis Y N Diabetes

Y N Stroke/TIA Y N Cancer: Type_____ Date_____

Y N Heart Problems Y N Pregnancy

How would you rate your general health? Poor Fair Good Excellent

What goals would you like to achieve in physical therapy? : _____

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