REDWOOD THERAPY

Today's Date: _____

Client Information

Patient Name _____
Last First Middle Initial

Gender: M □ F □ Date of Birth _____ Age _____ Social Security # _____

Marital Status (circle one): Single Married Widowed Divorced Separated

Name of Spouse/Parent/Guardian/Caregiver (circle one)

_____

Address _____

Home #_____Cell # _____ Email _____

May we call or leave messages for you at: **Home:** YES NO **Cell:** YES NO **Email:** YES NO

How did you learn about us? □ Doctor _____ □ Therapist _____

□ Web page □ Patient □ Wheelchair or Equipment Company □ Other _____

Emergency Contact: _____ Relationship _____

Emergency Contact Home # _____ Emergency Contact Cell # _____

May we have permission to speak with your Emergency Contact about your medical condition, needs, and account? YES NO

Physician Information

Referring Physician _____ Phone _____ Fax_____

Address _____

Patient's Primary Physician _____ Phone _____ Fax_____

Address _____

Primary Insurance Company: _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Social Security # _____ Policy Holder's Employer: _____

Policy Holder's Address (if other than patient's):

Address _____

Secondary Insurance Company: _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Social Security # _____ Policy Holder's Employer: _____

Policy Holder's Address (if other than patient's):

Address _____

Assignment of benefits/authorization to release information

I authorize payment of my insurance benefits directly to Redwood Therapy and authorize Redwood Therapy to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance.

REDWOOD THERAPY

Adult Photo and Videotape Release Form

I, the undersigned, hereby consent without further consideration or compensation, to give Redwood Therapy, the absolute right and permission to use my photograph or video in its promotional materials, publicity efforts, advertisements and social media.

I hereby grant permission to Redwood Therapy to crop, screen or alter the photograph or video as necessary for use on materials produced by and on behalf of Redwood Therapy. I understand that these images may be used alone or in conjunction with other photographs or videos for educational purposes, still or moving, sketches, advertising and publication in any manner and in any medium whatsoever without limitation or reservation.

I release all claims against Redwood Therapy, its employees, agents, and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.

I am 18 years of age or older.

x_____/_____/_____
Patient/Responsible Party Relationship to patient **Date**

Cancellation Policy

At Redwood Therapy, we value our professional relationships with our patients and their support system. In an effort to maximize our patients' clinical and therapeutic improvements, we have established the following guidelines for continued clinical assessment, treatment, and participation in all aspects of Redwood Therapy:

1. Cancellation of any Redwood Therapy appointment (assessment, treatment, home visit, Situational Assessment, or work visit) must be within **24 Hours** of the scheduled appointment time.

We require that you provide the courtesy of 24 hours cancellation notice *for illness*. Cancellations made with less than 24 hours notice will result in a **$50.00 cancellation fee** *per hour scheduled*. After two no shows in a treatment series, all future appointments will be cancelled, unless special arrangements are made.

If 3 appointments are cancelled with-in a treatment series all future appointments will be cancelled unless special arrangements are made.

x_____/_____/_____
Patient/Responsible Party Relationship to patient **Date**

x_____/_____/_____
Redwood Therapy Employee confirming cancellation/no show policy **Date**

Consent for Treatment

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

REDWOOD THERAPY

PATIENT QUESTIONNAIRE

This form was completed by:

☐ **Patient** ☐ **Parent** ☐ **Caregiver** ☐ **Friend** ☐ **Family Member** ☐ **Staff**

Patient Name: _____Height/Weight: _____Date of Birth: _____

TYPE OF INJURY

□ Stroke

Side of body affected: ☐ Right ☐ Left Dominant Hand Prior to stroke: ☐ Right ☐ Left
Date of stroke: _____Type of stroke_____

□ Traumatic brain injury (TBI)

Side of body affected: ☐ Right ☐ Left Dominant Hand Prior to TBI: ☐ Right ☐ Left
Date of TBI: _____Type of stroke_____

□ Spinal Cord Injury (SCI):

Injury Level:_____ Dominant Hand Prior to SCI: ☐ Right ☐ Left
Date of SCI: _____ Additional Comments:_____

□ Other:

Diagnosis or Injury:_____ Dominant Hand Prior to event: ☐ Right ☐ Left
Date of Injury or Diagnosis: _____ Additional Comments:_____

Reason for skilled Occupational Therapy:	**YES**	**NO**
Do you require assistance with dressing?		
Do you require assistance with bathing?		
Do you require assistance with toileting?		
Do you require assistance with movement of your arm(s)?		
Do you require assistance with movement of your leg(s)?		
Do you require assistance with household chores?		
Are you experiencing weaknesses in any part of your body?		
Do you have problems with coordination?		
Do you require assistance with cooking/meals?		
Have you fallen in the past year?		
Have you fallen in the past month?		
If so, when?		

Have you stumbled recently or are you fearful of falling?		
If yes, please explain:		

REDWOOD THERAPY

HEALTH INFORMATION

Please indicate if you have a history of any of the following conditions.

	YES	NO		YES	NO
Heart Disease			Cancer		
Hypertension			Depression		
Pulmonary Disease			Diabetes		
Head Injury or Surgery			Expressive Aphasia		
Thyroid Disease			Receptive Aphasia		
Seizures			Movement Disorder		
Anemia			Other:		
Allergies			Other:		
Asthma					

Current Medication List

Medication	Purpose

HEALTH INFORMATION CONTINUED

Please answer the following questions as part of your health history.

	YES	NO		Dates
Have you participated in skilled Occupational Therapy previously?			Why?	
Have you participated in any other therapies in the past?			Why?	
Are you participating in any other therapies currently?			Where?	
Are you scheduled for any future surgeries?			When?	
Are you currently employed or working?			Explain:	

Goals for Occupational Therapy:

REDWOOD
THERAPY