Patient Name:
Patient File #:

The
Rose Center
for
Rehabilitation, Hope & Wellness

I. Authorization for Treatment

I authorize THE ROSE CENTER licensed/certified staff to provide treatment as per my plan of care.

Initial _____

II. Contact information

- ❑ I give permission to be called regarding my appointments.
- ❑ You may leave a message at my home # _____
- ❑ You may leave a message at my work #_____
- ❑ You may leave a message on my cell #_____
- ❑ You may email my information if I ask you to. Email:

Initial _____

III. Authorization to pay THE ROSE CENTER

I hereby authorize my insurance benefits to be paid directly to THE ROSE CENTER. I understand that I am financially responsible for co-pays, deductibles, and non-covered services.

I authorize THE ROSE CENTER to release any information needed to process my insurance claim.

Initial _____

IV. HOME HEALTH / TREATMENT BY ANOTHER FACILITY AT THE SAME TIME

Out-patient physical therapy will be denied by Medicare and most insurance companies if:

- **Physical Therapy is performed at two clinics on the same day**
- **Home health services are currently in progress —**

CIRCLE: YES / NO

HOME HEATH CAN BE - Nursing, PT, Speech, OT, bathing assistance

If you have an open Home Healthcare case, you will be asked to sign an Advanced Beneficiary Notice (ABN).

Initial _____

Signature of Client: _____

V. Patient Information Consent

I have read and fully understand The Rose Center's NOTICE OF INFORMATION PRACTICES (available in lobby). I understand The Rose Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that The Rose Center will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Rose Center's NOTICE OF INFORMATION PRACTICES. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial _____

VI. Appointment Policy

Please allow one hour for your appointment. Please arrive 5-10 minutes prior to your appointment. New clients arrive 20 minutes prior to your Evaluation. If you need to cancel or reschedule your appointment, please give a 24-hour notice. If you do miss your appointment and you did not call, we can charge you $35.00 for the hour that you missed.

Initial _____

VII. Reason for visit:

- **Work Related: Yes / No**
- **MVA Related Yes / No**
- **Have had any visits of PT, OT, ST or chiropractic visits: yes / no**
- **How many visits this year? _____**

Date: _____

Guardian - Print Name: _____

Signature of Guardian: _____

Patient Name:
Patient File #:

The Rose Center for Rehabilitation, Hope & Wellness

Authorization for Release of Medical Information

Release of records FROM The Rose Center (please check the options below)

I hereby authorize **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS** at 3278 Bechelli Lane, Redding, CA, 96002 to disclose information from my records:

Name	Any records	Appointment Info Only
Family Member: _____	☐	☐
Family Member: _____	☐	☐
Caregiver: _____	☐	☐
Physician: _____	☐	☐
Transportation Company: _____	☐	☐
Vendor for Equipment: _____	☐	☐
Other: _____	☐	☐

Release of records TO The Rose Center (please check any that apply)

I hereby authorize the following companies and doctors to release my records of X-Rays, C-T scans, MRI, Notes and Reports to **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS** at 3278 Bechelli Lane, Redding, CA, 96002:

- ❑ MD imaging
- ❑ Advanced Imaging
- ❑ Shasta Regional Medical Center
- ❑ Mercy Medical Center
- ❑ Other: _____
- ❑ Other: _____

Consent Signature

I understand I may revoke this consent at any time, except where information has already been released.

Signature	Date	Witness	Date
Signature	Date	Witness	Date
Signature	Date	Witness	Date

Patient Name:
Patient File #:

The
Rose Center
for
Rehabilitation, Hope & Wellness

PAST MEDICAL HISTORY

Date Of Birth:_____ Date:_____

1. Please check if you have ever had:

☐ Arthritis/gout	☐ Low Blood Sugar	☐ Nausea/vomiting	☐ Difficulty walking
☐ Broken bone/fracture	☐ Head Injury	☐ Sudden weight loss	☐ Joint pain/swelling
☐ Osteoporosis	☐ Metal Implant	☐ Bowel problems	☐ Hearing problems
☐ Blood Disorders	☐ Cancer	☐ Urinary problems	☐ Vision problems
☐ Seizure/Epilepsy	☐ Skin Diseases	☐ Kidney problems	☐ Latex Allergy
☐ Heart Problems	☐ Pacemaker	☐ Repeated Infections	☐ Other:_____
☐ High Blood Pressure	☐ Lung Problems	☐ Neurological (Stroke, Parkinson, etc)	
☐ Migraines	☐ Thyroid Problems	☐ Developmental or growth problems	
☐ Cough	☐ Infectious Diseases	☐ Circulation/vascular problems	
☐ Coordination problems	☐ Pain at night	☐ Diabetes	
☐ Weakness in arms or legs	☐ Difficulty sleeping	☐ Ulcer/stomach problems	
☐ Loss of balance/falls	☐ Loss of appetite	☐ Mental Illness	

Please explain any box checked:_____

2. Within the past 6 months, have you had any of the following symptoms? (Check all that apply)

☐ Chest Pain	☐ Flu/Fever/chills/sweats	☐ Sores that haven't healed
☐ Heart Palpitations	☐ Headache	☐ Wart/Mole (changed in size, shape, color)
☐ Hoarseness	☐ Currently pregnant	☐ Other:_____
☐ Shortness of breath	☐ Unexplained weight loss	
☐ Dizziness or blackouts	☐ Smoke _____(how often?)	

3. Have you ever had surgery? (circle one) Yes No If yes, please describe and include dates: _____
_____

4. Please provide a list of your medications or any dietary supplements (ie calcium). ☐ See List ☐ None
5. List any allergies, including medications. ☐ See List ☐ Wrote on back
6. Diagnostic Studies:

	Date	By Whom?		Date	By Whom?
X-rays	_____	_____	Discogram	_____	_____
MRI	_____	_____	Arthrogram	_____	_____
CT Scan	_____	_____	Injections	_____	_____
Myelogram	_____	_____	VNG/ENG	_____	_____
EMG	_____	_____	Hearing	_____	_____

7. Do you exercise regularly? Yes No If yes, what type and how often? _____
8. Do you have discomfort, shortness of breath, or pain with exercise? Yes No
9. What is your occupation? Or retired from? _____

Patient Name:
Patient File #:

The
Rose Center
for
Rehabilitation, Hope & Wellness

Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale form 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you have any questions about answering any of these items, please ask the administrator.

The Activities-specific Balance Confidence (ABC) Scale*

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100%
No confidence Completely confident

How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper form the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tiptoes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

*Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1995;50(1): M28-34

3278 Bechelli Lane • Redding, CA 96002 • Country Club Shopping Center • (530) 223-9474 • Fax (530) 223-6937