



# The Rose Center

for  
Rehabilitation, Hope, & Wellness

Patient Name:  
Patient File #:

## 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: \_\_\_\_\_



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Patient File #:

## 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: _____	<input type="checkbox"/>	<input type="checkbox"/>
Family Member: _____	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physician: _____	<input type="checkbox"/>	<input type="checkbox"/>
Transportation Company: _____	<input type="checkbox"/>	<input type="checkbox"/>
Vendor for Equipment: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

### 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:

- |   |   |
|---|---|
| <input type="checkbox"/> MD Imaging                     | <input type="checkbox"/> Mercy Medical Center |
| <input type="checkbox"/> Advanced Imaging               | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Shasta Regional Medical Center | <input type="checkbox"/> 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



# The Rose Center

for  
*Rehabilitation, Hope & Wellness*

**Patient Name:**  
**Patient File #:**

## PAST MEDICAL HISTORY

Date Of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

1. Please check if you have ever had:

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Flu/Fever/chills/sweats  | <input type="checkbox"/> Sores that haven't healed                 |
| <input type="checkbox"/> Heart Palpitations     | <input type="checkbox"/> Headache                 | <input type="checkbox"/> Wart/Mole (changed in size, shape, color) |
| <input type="checkbox"/> Hoarseness             | <input type="checkbox"/> Currently pregnant       | <input type="checkbox"/> Other: _____                              |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Unexplained weight loss  |  |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> 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? \_\_\_\_\_