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 HEALTH 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 Client: _______________________

Signature of Guardian: _______________________

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Any records</th>
<th>Appointment Info Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member:</td>
<td></td>
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<tr>
<td>Family Member:</td>
<td></td>
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<tr>
<td>Caregiver:</td>
<td></td>
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<tr>
<td>Physician:</td>
<td></td>
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<tr>
<td>Transportation Company:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vendor for Equipment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Witness</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Signature</td>
<td>Date</td>
<td>Witness</td>
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</tbody>
</table>
### PAST MEDICAL HISTORY

1. Please check if you have ever had:

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

- [ ] Arthritis/gout
- [ ] Broken bone/fracture
- [ ] Osteoporosis
- [ ] Blood Disorders
- [ ] Seizure/Epilepsy
- [ ] Heart Problems
- [ ] High Blood Pressure
- [ ] Migraines
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- [ ] Kidney problems
- [ ] Repeated Infections
- [ ] Neurological (Stroke, Parkinson, etc)
- [ ] Developmental or growth problems
- [ ] Circulation/vascular problems
- [ ] Diabetes
- [ ] Ulcer/stomach problems
- [ ] Other:

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

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:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>By Whom?</th>
<th>Date</th>
<th>By Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td></td>
<td></td>
<td>Discogram</td>
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<tr>
<td>MRI</td>
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<td>Arthrogram</td>
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<tr>
<td>CT Scan</td>
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<td>Injections</td>
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<tr>
<td>Myelogram</td>
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<td>VNG/ENG</td>
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<td>EMG</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
</tr>
</tbody>
</table>

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?