

Bold fields are required.

Date _____

Name (First, MI, Last) _____

DOB _____

Address _____

City, State, Zip Code _____

Home Phone _____

Work Phone _____

Mobile Phone _____

Emergency Contact Name _____ **Phone** _____

Relationship _____

Responsible Party Name _____ **DOB** _____

E-Mail _____

PCP or referring Physician _____

Address _____

City, State, Zip Code _____

Work Phone _____

Fax Phone _____

Medicare Patient? Yes No

How did you hear about us? _____

I give Rob Rosenberry permission to consult with my referring health care provider regarding my health and treatment.

Signature _____

Current Health Information

Please list concerns and check all that apply

What is your Primary Complaint? _____

- mild moderate severe
 constant intermittent
 symptoms up w/activity symptoms down w/activity
 getting worse getting better no change

Treatment received _____

What is your Secondary Concern? _____

- mild moderate severe
 constant intermittent
 symptoms up w/activity symptoms down w/activity
 getting worse getting better no change

Treatment received _____

Any Additional Complaints? _____

- mild moderate severe
 constant intermittent
 symptoms up w/activity symptoms down w/activity
 getting worse getting better no change

Treatment received _____

Have you ever received Manual Therapy before?

Yes No Frequency? _____

If Yes, what are they? _____

Daily Activities

Describe how your condition functionally limits the following activities.

Work _____

Home/Family _____

Recreational _____

Check other activities affected:

- sleep washing dressing fitness

How do you reduce stress? _____

In general, do you prefer to sit or stand? _____

If you are in acute pain, what is your most comfortable position?

Health History (continue on back)

Are you taking any medications? _____

List and explain. Include dates and treatment received.

Surgery _____

Accidents _____

Major Illnesses _____

General

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	pain _____
<input type="checkbox"/>	<input type="checkbox"/>	sleep disturbance _____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever _____
<input type="checkbox"/>	<input type="checkbox"/>	sinus _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Skin Conditions

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	rashes _____
<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Allergies

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions _____
<input type="checkbox"/>	<input type="checkbox"/>	detergents _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Muscles and Joints

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis _____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis _____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones _____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems _____
<input type="checkbox"/>	<input type="checkbox"/>	disc problems _____
<input type="checkbox"/>	<input type="checkbox"/>	lupus _____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain _____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps _____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains _____
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis, bursitis _____
<input type="checkbox"/>	<input type="checkbox"/>	stiff or painful joints _____
<input type="checkbox"/>	<input type="checkbox"/>	weak or sore muscles _____
<input type="checkbox"/>	<input type="checkbox"/>	neck, shoulder, arm pain _____
<input type="checkbox"/>	<input type="checkbox"/>	low back, hip, leg pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Nervous System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	head injuries _____
<input type="checkbox"/>	<input type="checkbox"/>	concussions _____
<input type="checkbox"/>	<input type="checkbox"/>	dizziness _____
<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of memory _____
<input type="checkbox"/>	<input type="checkbox"/>	confusion _____
<input type="checkbox"/>	<input type="checkbox"/>	numbness _____
<input type="checkbox"/>	<input type="checkbox"/>	tingling _____
<input type="checkbox"/>	<input type="checkbox"/>	sciatica _____
<input type="checkbox"/>	<input type="checkbox"/>	shooting pain _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic pain _____
<input type="checkbox"/>	<input type="checkbox"/>	depression _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Respiratory & Cardiovascular

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	heart disease _____
<input type="checkbox"/>	<input type="checkbox"/>	blood clots _____
<input type="checkbox"/>	<input type="checkbox"/>	stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	lymphedema _____
<input type="checkbox"/>	<input type="checkbox"/>	high/low blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat _____
<input type="checkbox"/>	<input type="checkbox"/>	poor circulation _____
<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles _____
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins _____
<input type="checkbox"/>	<input type="checkbox"/>	chest pain _____
<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath _____
<input type="checkbox"/>	<input type="checkbox"/>	asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	COPD _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Cancer/Tumors

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Benign _____
<input type="checkbox"/>	<input type="checkbox"/>	Malignant _____

Digestive/Elimination system

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	bowel dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Endocrine System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____

Reproductive System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy _____
<input type="checkbox"/>	<input type="checkbox"/>	painful menses _____
<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts _____

Habits

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	tobacco _____
<input type="checkbox"/>	<input type="checkbox"/>	alcohol _____
<input type="checkbox"/>	<input type="checkbox"/>	drugs _____
<input type="checkbox"/>	<input type="checkbox"/>	coffee _____
<input type="checkbox"/>	<input type="checkbox"/>	ergogenic aides _____

Movement & Exercise

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Stretching/Yoga _____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiorespiratory _____
<input type="checkbox"/>	<input type="checkbox"/>	Strength/Resistance _____
<input type="checkbox"/>	<input type="checkbox"/>	balance/speed/agility _____

Contract for Care & Consent for Care

Contract for Care. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by Rob Rosenberry and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform Rob Rosenberry time I feel my well being is threatened or compromised. I expect Rob Rosenberry to provide safe and effective treatment.

Consent for Care. It is my choice to receive *bodywork/manual therapy*, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my *manual therapist* of any changes in my health.

Signature/Date of parent or Signature/Date

Signature/Date of parent or guardian if patient is a minor.

INFORMED CONSENT and PATIENT AGREEMENT

I, the undersigned, hereby authorize ROB ROSENBERY, to perform bodywork manual therapy and specific procedures necessary for Fascial Counterstrain (FCS) treatment.

What is Fascial Counterstrain (FCS)?

Fascial Counterstrain is a technique that uses gentle manual manipulations to help restore function to the fascial systems of the body (arterial, visceral, lymphatic, venous, dural, periosteal, and nervous systems). Benefits of FCS include stress reduction, circulation enhancement, increased relaxation, and relief from muscular tension, soreness, and pain.

Limitations of FCS:

FCS practitioners do not diagnose medical diseases or conditions and it is not a substitute for medical examination and treatment.

Self-care after treatment:

- Following a session, please make sure to consume at least 8-10 glasses of pure water.
- Try to avoid heavy lifting or heavy physical activity for the week following a session. If a simple position of comfort was enough to reduce pain, a simple painful effort is enough to restore it.
- If you receive handouts for home exercises, perform them at least once in the evening, every evening, or if you begin to feel any symptoms return.

NOTE: Please understand that despite the gentle nature of the fascial counterstrain technique, there is a very real possibility that you will get sore following a session. Sometimes in extreme cases you may feel worse. In most cases this is evidence of a powerful change in your body, not another injury. Usually, this is temporary and should not last more than 2-3 days. There is no way to predict how one will respond to fascial counterstrain treatment, but you can minimize the reaction by following the guidelines listed above.

Adverse Reactions to FCS:

Please provide complete details of medical conditions and medications to your treatment provider during the health-intake interview. Failure to inform the manual therapist of all medical conditions and medications may place you at increased risk for adverse reactions. If you experience any discomfort during the session, immediately inform your practitioner so he or she can adjust your treatment. Sometimes treatment is followed by temporary soreness, fatigue or discomfort related to tissue toxicity and the early stages of detoxification.

Informed Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that has given no guarantees to me regarding cure or improvement of my condition. I hereby release ROB ROSENBERY from any and all liability, which may occur in connection with the above-mentioned procedures except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that

FCS bodywork requires practitioners to gently touch and manipulate my body. I understand that FCS bodywork is not a method to diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of FCS bodywork. I understand that FCS bodywork is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have and I have stated all my known physical conditions and medications. I also understand the benefits and limits of FCS bodywork and understand it may cause adverse reactions in certain rare situations. I release my practitioner of any liability if I fail to disclose the appropriate health-related information.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that my practitioner will answer any questions I have.

I authorize the therapists of ROB ROSENBERY to provide treatment to my child or dependent.

Client's Signature: _____ Date: _____

Name of Child or Dependent: _____

Parent or Guardian Signature: _____ Date: _____

Rob Rosenberry
320 Alisal Road, Suite 406
Solvang, CA 93463

Phone: (805) 688-5000
Email: info@robrosenberry.com

PAYMENT, BILLING AND CANCELLATION POLICIES

Business Rates and Billing: The current rate for manual therapy and bodywork is \$225 per hour. Additional time, beyond the first hour of treatment, is not included in the initial charge. If additional time is used you will be charged an additional amount in proportion to the extra time.

For Clinic Director

- 1 hour 15 minutes = \$280.00
- 1 hour 30 minutes = \$335.00
- 1 hour 45 minutes = \$390.00
- 2 hours = \$445.00

ROB ROSENBERRY accepts cash, checks and all major credit cards. We do not bill insurance companies for services. Plan to arrive 10 minutes early to complete your paperwork. Clients arriving late will be charged for the full session and the session will end promptly at the scheduled time. Clients must cancel sessions per the notice requirements stated below or pay for the missed appointment in full.

New Patients:

New Patients are required to provide credit card information to hold their initial appointment time. Your credit card will not be charged at time of booking and will not be charged in the case that a cancellation is made with appropriate notice given per the terms stated below.

Medicare Patients:

Due to the specialized nature of wellness services provided at ROB ROSENBERRY our clinic does not accept Medicare. By signing this form, you are agreeing that you understand these policies and that you will not seek reimbursement through Medicare for any services provided or expenses incurred at ROB ROSENBERRY.

Cancellation Policy: All services are provided by appointment only and this time is reserved for your exclusive use. It is your responsibility to attend all scheduled appointments. Should you need to cancel an appointment, please refer to the below chart which details how far in advance appointments must be canceled in order to avoid incurring fees:

Length of Appointment	Required Notice for Cancellation
One Hour	24 Hours
Two Hours	2 Business Days
Three + Hours	3 Business Days

These requirements allow the time needed for your appointment to be given to someone else. Except in emergency situations, *not showing for an appointment without the correct amount of notice given will be charged the full rate of the scheduled appointment.* This fee is your responsibility.

NOTE: *Reminder calls are a courtesy service;* ultimately it is your responsibility to arrive for an appointment that you have scheduled. Not receiving a reminder call does not waive your responsibility to cancel or postpone an appointment at least 24 hours ahead of time. You will be charged for your appointment if this happens.

Extended Appointments: Reserving more than 12 hours per week will require a deposit for the first four hours to be paid when scheduling the appointment. Deposits will not be refunded if an extended appointment is canceled within 72 business hours before the first appointment. For example, an appointment that begins at 9:00am on a Monday would require notification by 9:00am on the Wednesday preceding the Monday appointment.

NOTICE OF PATIENT INFORMATION AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN BELOW.

USES AND DISCLOSURES OF HEALTH INFORMATION

My "protected health information" means health information, including my demographic information, collected from me and created or received by ROB ROSENBERY, another health care provider, a health plan, my employer, or a health care clearinghouse.

I consent to the use or disclosure of my protected health information by ROB ROSENBERY for the purpose of providing treatment to me, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care we provide. ROB ROSENBERY may use my information to contact me, provide appointment reminders, or correspond with my health care providers whom I have approved in writing, about my health care and treatment related information.

I understand that ROB ROSENBERY may use or disclose my personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. ROB ROSENBERY will also provide information when required by law. ROB ROSENBERY may change its policy at any time. When changes are made, a new "Notice of Privacy Practices" will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of the "Notice of Privacy Practice" at any time.

In any other situation, ROB ROSENBERY will obtain my written authorization before disclosing my personal health information. I have the right to revoke this consent, in writing, in any time to stop future disclosures of my information.

PATIENT RIGHTS

I have the right to review or obtain a copy of my personal health information at any time. I have the right to request a correction for any inaccurate or incomplete information in my records. I have the right to request a record of instances in which ROB ROSENBERY has disclosed my personal health information for reasons other than treatment, payment or other related administrative purposes.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the clinic. I also understand that ROB ROSENBERY considers such requests on a case by case basis, but the practice is not legally required to accept them. However, if ROB ROSENBERY agrees to a restriction that I request, the restriction is binding on ROB ROSENBERY.

CONCERNS AND COMPLAINTS

If you are concerned that ROB ROSENBERY may have violated your rights or if you disagree with any decisions ROB ROSENBERY has made regarding access or disclosure of your personal health information, please contact the practice manager. You may also send a written complaint to the US Department of Health and Human Services.

By signing below I acknowledge that I have read and understand how ROB ROSENBERY will use my personal health information and what my rights are with regards to disclosure and restriction of my personal health information.

Patient Signature: _____ Date: _____