

## Active Release Technique

### Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Hm \_\_\_\_\_ Mobile \_\_\_\_\_

Work \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: M S W D

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Who should we thank for this referral? \_\_\_\_\_

Problems to be treated: \_\_\_\_\_

\_\_\_\_\_

When and how did this problem begin? \_\_\_\_\_

\_\_\_\_\_

Have you ever been treated for this problem before? If yes how so? \_\_\_\_\_

\_\_\_\_\_

Does your pain limit you from doing any activities? \_\_\_\_\_

\_\_\_\_\_

Do you have any other health issues at this time? \_\_\_\_\_

\_\_\_\_\_

Each patient is assigned a pin to check in at the front desk, which telephone number would you like to use as you pin? \_\_\_\_\_

Our office sends mandatory notifications to confirm appointments by either **text OR email**.

**To receive text:**

**To receive email notification:**

Cell Phone number \_\_\_\_\_

Email address \_\_\_\_\_

Carrier (ex: AT&T, Verizon) \_\_\_\_\_

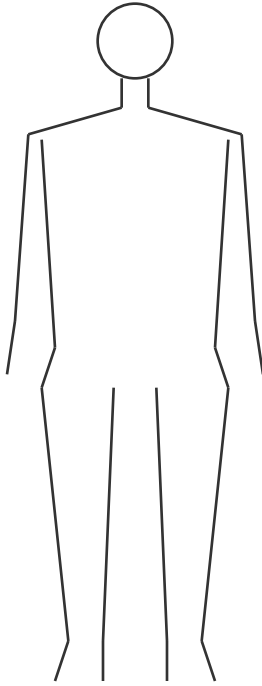
NAME \_\_\_\_\_

DATE \_\_\_\_\_

## Show Me Where It Hurts

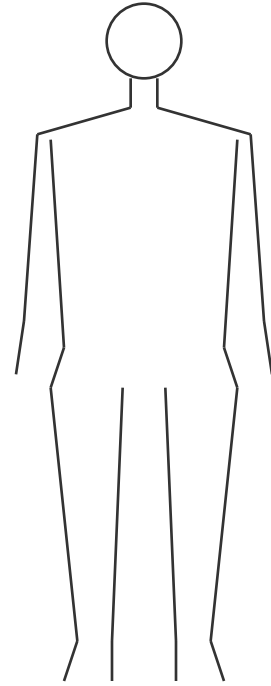
Mark these drawings according to where you hurt. If you feel any of the following symptoms, please indicate where you feel them by placing the LETTER shown here on the diagram.

**FRONT**



**FRONT**

**BACK**



**BACK**

**ACHING**

**A**

**BURNING**

**B**

**NUMBNESS**

**N**

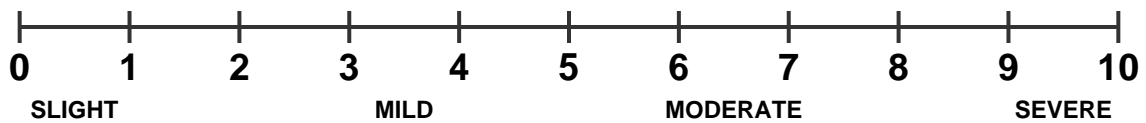
**STABBING**

**S**

**TINGLING**

**T**

**PLEASE CIRCLE YOUR LEVEL OF PAIN**



# Appointment Policies for Cory Harris

\* So that we may provide sufficient time for all of our patients, please be courteous and call the office promptly if you are unable to attend your appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance.

**Failure to do so may result in your credit card being charged a cancelation fee that could be up to the total cost of your appointment.**

\*Therapy appointments usually run on time. If you are late for your appointment, your appointment time will be reduced. Your initial evaluation/treatment will be about 40 minutes for \$170.00. Follow up appointments are 20 minutes for \$85.00. If you have multiple areas to be treated, a 40-minute appointment for \$150.00 is recommended.

\*Please wear appropriate clothing that will allow treatment to be done directly on skin. For example:

Low back, hip or knee pain, please wear flexible shorts.

Neck, shoulder or upper back pain, please wear tank top shirts.

\*Cory Harris is credentialed in Active Release Therapy. He **CANNOT** provide diagnosis codes. Most insurance companies require a diagnosis code to process a claim.

If you have any questions, please feel free to consult with our staff. We are all here to make your therapy visit as effective and pleasant as possible.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

## Sheppard Spine and Sports Clinic's Privacy Policy Short Form

Safeguarding your health information is important to us. As providers of care, we have certain practices to help protect your health information. This summarizes some of those privacy practices that are used by Sheppard Spine and Sports Clinic. You are entitled to receive and review our full length legal notice of privacy practices that you may obtain at our office or by calling (858) 350-6290.

The Health Insurance Portability and Accountability Act of 1996, or HIPPA allows the use of certain health information for the following activities:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations or when permitted by HIPPA. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

If our use or disclosure is not for one of the activities described above and is not otherwise permitted under HIPPA, we will ask you to complete a written authorization before we use or release your health information. When receiving services from us, you will also be able to decide whether we can discuss your health information with your family and friends.

Even if you have provided us with your authorization, you may withdraw that authorization, in writing, at any time to stop future disclosures of your health information.

HIPPA provides you with the following rights:

Restricting a use/disclosure, requesting confidential communications, inspecting and obtaining copies of your health information, requesting a change in your health information, requesting an accounting of disclosures of your health information, obtaining notice of our privacy policies.

If you believe that the privacy of your health information has been violated, you may contact us to discuss your concern or file a complaint at 858-350-6290 or 634 Stevens Ave. Solana Beach, CA 92075. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

By signing this form, you consent to our use and disclosure of your protected health information as indicated above and in the full length Notice of Privacy Practices. Please note that your personal information is not shared with third parties and use is restricted to procedures that are relevant to your care.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_