BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • PHYSICAL THERAPY BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 2600, Sacramento, CA 95815
P (916) 561-8215 | (800) 832-2251 | F (916) 263-2560 | cps@dca.ca.gov
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INSTRUCTIONS FOR FILING A COMPLAINT AGAINST A LICENSED PHYSICAL THERAPIST, PHYSICAL THERAPIST ASSISTANT, AND/OR AN UNLICENSED PERSON PRACTICING PHYSICAL THERAPY

The function of the Physical Therapy Board of California (PTBC) is to protect the public from the incompetent, unprofessional, and/or unlawful practice of physical therapy. To fulfill this mission the PTBC investigates the background of applicants, licensed physical therapists, and physical therapist assistants, and the unlicensed practice of physical therapy.

The specific California statutes and regulations related to the practice of physical therapy are contained in the Physical Therapy Practice Act (Business and Professions Code §2600-2696, California Code of Regulations (Title 16, Division 13.2), and other pertinent sections of the Business and Professions Code.

Instructions for Filing Your Complaint

Except for the name of the physical therapist/physical therapist assistant or person your complaint is against, all information requested is voluntary, but failure to provide this information may delay or prevent the investigation of your complaint. Please provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, such as the Attorney General's Office. In completing the complaint form, please do all of the following:

1. Legibly print or type all information.
2. Fill in the full name, address, telephone number, and license number (if known) of the person your complaint is against. This information must also be included in the corresponding section of the Authorization for Release of Patient Health Information Form.
3. Write your complaint in a narrative format and include details such as (dates, names, titles, specific concerns about the treatment provided, and the name(s) and contact information of any witnesses).
4. Attach a copy of any supporting documents you may have in your possession pertaining to your specific complaint. Supporting documents may include patient records, photographs, audio or video recordings, correspondence (e.g. letters, emails, texts), billing statements, proof of payments, police reports, and court documents, internal employment administrative investigations, etc.
5. Complete the **"Authorization for Release of Patient Health Information".** This form is necessary to obtain information from the provider you are complaining about.
6. If you were treated by another provider or health facility related to your complaint, please complete one of the following medical release forms in their entirety:

   "Other Provider/Facility Authorization for Release of Patient Health Information" (In this form, list all other treating providers or facilities relevant to your complaint. You can add up to three (3) per form.

   -OR-

   "Kaiser Authorization for Release of Patient Health Information" (If the care and treatment related to

your complaint was rendered at a Kaiser facility, fill out the Kaiser form and check if it's a "northern" or "southern" facility).

7. Sign and date the complaint form.

Please Note:

- You must fill out a separate complaint form for each physical therapist, physical therapist assistant, or unlicensed provider you would like to complain about.

- The PTBC does not have jurisdiction over billing/fee disputes, general business practices (contracts, office policies, appointment times/duration, etc.) or personal conflicts, unless the behavior in question interferes with the safe delivery of patient care. The PTBC cannot award any kind of financial compensation, provide legal advice, or assist with lawsuits.

- Please be advised that the Board cannot assist with any coordination of patient care. Should you require assistance please contact your insurance company or medical providers.

Authorization for Release of Medical Information

The Authorization for Release of Patient Health Information form authorizes the Physical Therapy Board to obtain medical information and patient records regarding the patient's physical therapy care from the licensee and/or the facilities involved with the physical therapy care provided.

Print or type the patient's name, date of birth, date of death, if patient is deceased, and medical record number (if known). Include the name of the provider, facility name and address, and phone number as outlined in your complaint.

The Authorization for Release of Patient Health Information form must be signed and dated by either the patient or the individual legally authorized to make medical decisions for the patient. If the patient is unable to sign, the form may be signed by:

1) the next of kin if the patient is deceased (**provide copy of death certificate)**
2) the parent of a minor child
3) the person named by the patient in a signed Power of Attorney granting the person authority to make medical decisions for the patient

*** Should the patient be deceased, the person signing the release form(s) must be a legal representative as demonstrated on a durable power of attorney, death certificate, or an executor of will/estate document. **(Please enclose copies of supportive documentation).**

Do not add extra comments or notations on the Release of Patient Health Information form as this will VOID the form and you will be asked to complete another.

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COMPLAINT REGISTERED AGAINST

Check one: ☐ **Physical Therapist** ☐ **Physical Therapist Assistant** ☐ **Physical Therapist Aide** ☐ **Other**

SUBJECT INFORMATION

Last Name	First Name	Middle Initial	License Number
Office/Facility Name			Phone Number
Street Address			
City	State	Zip Code	

Reason for Treatment:

Date(s) of Treatment:

Has the patient been examined/treated by another professional for this same condition? ☐ **NO** ☐ **YES**

If yes, complete the form “OTHER PROVIDER/FACILITY AURTHORIZATION FOR RELEASE OF HEALTH INFORMATION” attached below.

PERSON REGISTERING COMPLAINT

Last Name	First Name	Middle Initial
Street Address		
City	State	Zip Code
Phone Number	Email Address	

PATIENT INFORMATION

Patient’s Name	Patient’s Date of Birth
Your Relationship to Patient	

Nature of Complaint

Check the box that best describes the nature of your complaint:

- ☐ **Substandard Care** (e.g. Negligent Treatment, Delay in Treatment, etc.)
- ☐ **Unlicensed Provider or Aiding/Abetting the unlicensed practice**
- ☐ **Sexual Misconduct/Harassment**
- ☐ **Unprofessional Conduct** (e.g. Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest, or Conviction
- ☐ **Office Practice** (e.g. Failure to Provide Medical Records to Patient, Patient Abandonment)
- ☐ **Provider Impairment** (e.g. Drug, Alcohol, Mental, Physical)
- ☐ **Other**

Notice: Pursuant to Section 129 of the Business and Professions Code, "…Each board shall, upon receipt of any complaint respecting a licentiate thereof, notify the complainant of the initial administrative action taken on his complaint within ten days of receipt…"

DETAILS OF COMPLAINT (Attach additional pages if necessary)
State your complaint in chronological order and in detail. In addition, please include dates of treatment and list all relevant treating providers specific to your complaint. It is important that you be specific regarding any allegations of substandard care. Providing a comprehensive narrative of your complaint allows for a more expeditious review process.

DETAILS OF COMPLAINT (continuation from page 5)	
Signature	**Date**

NOTICE ON COLLECTION OF PERSONAL INFORMATION

Collection and Use of Personal Information. The Department of Consumer Affairs (DCA) and the Physical Therapy Board of California (PTBC) collects the information requested on this form as authorized by Business and Professions Code sections 325 and 326 and the Information Practices Act (Civil Code section 1798 and following). The PTBC uses this information to follow up on your complaint in accordance with DCA's Privacy Policy.

Providing Personal Information is Voluntary
You do not have to provide the personal information requested. If you do not wish to provide personal information, such as your name, home address, or home telephone number, you may remain anonymous. In that case, however, the PTBC may not be able to contact you or help you resolve your complaint.

Access to Your Information
You may review the records maintained by the PTBC that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information
The PTBC makes every effort to protect the personal information you provide. However, in order to follow up on your complaint, the PTBC may need to share the information you provided with the licensee you complained about or with other government agencies. This may include sharing any personal information you provided.

The information you provide may also be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code section 7920 and following), as allowed by the Information Practices Act.
- Disclosure to another government agency as required by state or federal law.
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information
For questions about this notice or for access to your records, contact the Physical Therapy Board of California, 2005 Evergreen Street, Suite 2600, Sacramento, CA 95815, (916) 561-8215, or by email at cps@dca.ca.gov. For questions about DCA's Privacy Policy, contact the Department of Consumer Affairs at 1625 North Market Boulevard, Sacramento, CA 95834, by phone at (800) 952-5210, or by email at dca@dca.ca.gov.

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

☐ Physical Therapy and Billing Records ☐ Diagnostic Images

PATIENT INFORMATION

Patient Name

Date of Birth

Medical Record Number (If known) Or SSN

Date of Death (If applicable)

Continued on Page 9

Patient Name:	

I, the undersigned hereby authorize:

Physical Therapist/Assistant		
Facility Name		
Facility Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

to provide records in the course of my treatment, including physical therapy, medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the PHYSICAL THERAPY BOARD OF CALIFORNIA, CONSUMER PROTECTION SERVICES, a healthcare oversight agency. This disclosure of records, authorized herein, is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Physical Therapy Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Physical Therapy Board of California, 2005 Evergreen Street, Suite 2600, Sacramento, CA 95815.

My written revocation will be effective upon receipt by the Physical Therapy Board of California but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations.

______________________________ ______________

Patient Signature Date

- OR -

______________________________ ______________

Legal Representative Name Relationship to Patient

______________________________ ______________

Legal Representative Signature Date

Note: Pursuant to Business and Professions Code, section 2660.4, a licensee who fails or refuses to comply with a request from the board for the medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the records have not been produced after the 15th day, unless the licensee is unable to provide the records within this time period for good cause. This release is compliant with the requirements of HIPAA and Civil Code section 56.11.

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OTHER PROVIDER/FACILITY AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

☐ Physical Therapy and Billing Records ☐ Diagnostic Images

PATIENT INFORMATION

Patient Name
Date of Birth
Medical Record Number (If known) or SSN
Date of Death (If applicable)

I, the undersigned hereby authorize:

Other Provider/Facility (1)		
Street Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

Other Provider/Facility (2)		
Street Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

Continued on Page 11

Patient Name:			
Other Provider/Facility (3)			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

to provide records in the course of my treatment, including physical therapy, medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the PHYSICAL THERAPY BOARD OF CALIFORNIA, CONSUMER PROTECTION SERVICES, a healthcare oversight agency. This disclosure of records, authorized herein, is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Physical Therapy Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

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Patient Signature | Date

- OR -

Legal Representative Name | Relationship to Patient

Legal Representative Signature | Date

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KAISER AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

☐ Physical Therapy Records ☐ Diagnostic Images

PATIENT INFORMATION

Patient Name

Date of Birth

Medical Record Number (If known) of SSN

Date of Death (If applicable)

Continued on Page 13

Patient Name:	

I, the undersigned hereby authorize:

☐ Kaiser Permanente (Northern Facilities)

☐ SCPMG/Kaiser Foundation Hospital (Southern Facilities)

Treatment Date(s)

to provide records in the course of my treatment, including physical therapy, medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the PHYSICAL THERAPY BOARD OF CALIFORNIA, CONSUMER PROTECTION SERVICES, a healthcare oversight agency. This disclosure of records, authorized herein, is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Physical Therapy Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

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Patient Signature | Date

- OR -

Legal Representative Name | Relationship to Patient

Legal Representative Signature | Date

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