OCEAN BEACH PHYSICAL THERAPY NEW PATIENT FORM

PRINT CLEARLY

Name: (first)_____(last)_____ (m.i) _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Sex: ◉ Male ○ Female **Student** ◉ Yes ○ No

Home Ph: (____) _____ **Age:** _____ **Date Of Birth**: _____

Cell Ph: (____) _____ **Statement Preference**: ☐ E-mail ☐ Fax ☐ Mail

Work Ph: (____) _____ **SSN:** _____

Fax: (____) _____ **Drivers Lic:** _____

Employment Status: ◉ Full Time ○ Part Time ○ Not Working ○ Retired **Employer:** _____

Address: _____ **Phone:** (____) _____

Marital Status: ◉ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Domestic Partner ○ Minor

Emergency Contact: _____

Name of Spouse: _____ **Relationship:** _____

Age: _____ **Birth Date**: _____ **Phone** (____) _____

Referring Physician (if applicable) _____ **Phone:** (____) _____

Who may we thank for your referral other than your Doctor? _____

Injury Type: ◉ work ○ auto ○ home ○ other _____ **Injury Date:** _____

Lawyer involved? ◉ Yes ○ No **Claim / Authorization / Referral #** _____

Attorney Name: _____ **Phone:** (____) _____

Address _____

Primary Insurance _____

Subscriber Social Security # _____ **Date-of-Birth** _____

Secondary Insurance _____

Subscriber Social Security # _____ **Date-of-Birth** _____

All professional services rendered are the ultimate responsibility of the patient

Patient Signature: _____ **Date** _____

(OFFICE USE ONLY)

Financial Class: WC PRVT MC CASH LIEN HMO

POTRERO PHYSICAL THERAPY — MEDICAL HISTORY

Patient Name: _____ **Age**: _____

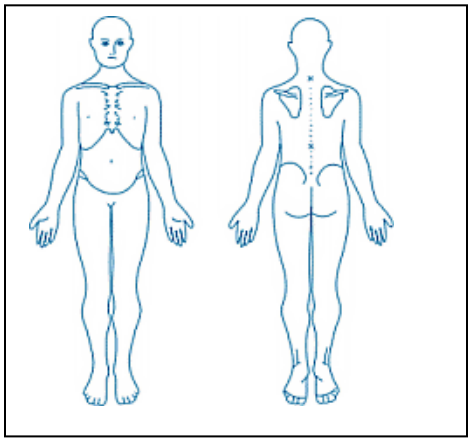
Type of Injury / Condition: _____

Onset / Injury Date: _____

Type of Surgery: _____ **Date:** _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition _____



Have you recently noted:

- ☐ Weight loss /gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Nausea / Vomiting
- ☐ Fever / chills / sweats

Have you EVER been diagnosed as having any of the following?

- ☐ Cancer
- ☐ Circulation problems, clots
- ☐ Chemical dependency, alcoholism
- ☐ Multiple sclerosis
- ☐ Ulcer
- ☐ Stroke
- ☐ Heart problems, Murmur
- ☐ Asthma, Breathing Problems
- ☐ Thyroid problems
- ☐ Rheumatoid arthritis
- ☐ Hernia
- ☐ Epilepsy, seizures
- ☐ High Blood Pressure
- ☐ Lung disease
- ☐ Diabetes
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Pacemaker/ Metal Implant

Do you have now or have you ever had any of the following?

- ☐ Headaches
- ☐ Abdominal Pain
- ☐ Change in Vision or Hearing
- ☐ Urinary Problems/Infections
- ☐ Unusual Shortness of Breath
- ☐ Pain at night
- ☐ Indigestion/Heartburn
- ☐ Injured Motor Vehicle Accident
- ☐ Repetitive Nausea, Vomiting
- ☐ Dizziness
- ☐ Long Standing Constipation
- ☐ Releasing Urine (coughing or sneezing)
- ☐ Easy Bruising/Bleeding
- ☐ Cramps in Legs when walking
- ☐ Fainting
- ☐ Any previous injury that may affect current care
- ☐ Neck Swelling/Lumps
- ☐ Recurrent Diarrhea
- ☐ Trouble Swallowing
- ☐ Hurried Need to Urinate
- ☐ Leg/Ankle swelling
- ☐ Insomnia
- ☐ Allergies / Skin sensitivity

Explain & give approximate dates for any items indicated above _____

Are you currently taking medications? ○ Yes ○ No Name or Type of Medication _____

Type of pain: ○ sharp ○ burning ○ aching ○ tingling ○ numbness ○ other _____

Does pain radiate to arms and / or legs _____

Rate your pain (average) on a 1-10 scale (1=minimal 10=severe) _____

Is there anything else you would like to include? _____

Patient Signature _____ **Date** _____

Therapist Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature **Date**

POTRERO PHYSICAL THERAPY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Potrero Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Potrero Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Potrero Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. There is a $75 charge for cancellation without proper notice (24 hours). This charge will not be covered by insurance, but will have to be paid by you personally.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $ _____

Arrangements for payment of patient's co-pay/deductible **(circle one):**

Will pay each Visit **Will pay weekly in Advance**

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient/Guardian/Responsible Party **Date**

_____

Center Representative **Date**

CANCELLATION & NO-SHOW POLICY

We require 24 hours notice in the event of a cancellation. There is a **$75 charge** for cancellations without proper notice. This charge will not be covered by insurance, and will have to be paid by you personally. After 3 cancellations you may be discharged from physical therapy for non-compliance.

Please let us know how you would like to pay this fee in the event of a last minute cancellation.

◉ I will bring my payment at time of next visit.

○ Please send me an invoice for the cancellation payment.
Via: Email: _____

Mailing Address _____
_____
_____

○ Please bill my credit card:
Credit Card #: _____

Expiration Date: _____

_____ _____
(Initial) (Date)

Effective Nov. 1, 2014

IN NETWORK		OUT OF NETWORK	
DEDUCTIBLE		DEDUCTIBLE	
DEDUCTIBLE MET		DEDUCTIBLE MET	
CO PAY		CO PAY	
CO INSURANCE		CO INSURANCE	
VISIT LIMIT		VISIT LIMIT	
VISITS USED		VISITS USED	
RX REQUIRED	YES NO	RX REQUIRED	YES NO

_____ _____
(Initial) (Date)

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. **You are responsible for your bill, it is your responsibility to confirm insurance coverage for services**. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $_____

No Refunds on Advance Payments for 5/visits @ $550. Unused visits expire a year from 1st date of service

Arrangements for payment of patient's co-pay/deductible **(circle one):**

Will pay each Visit **Will pay weekly in Advance**

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient/Guardian/Responsible Party **Date**

_____

Clinic Representative **Date**