Pasadena Physical Therapy **NEW PATIENT FORM**

PLEASE PRINT CLEARLY

Date ____________________

Patient Name ________________________________ **Date of Birth** _____________

Home Address ____

City ______________________________ State ________ Zip Code ______________

Best Phone # to Reach You ____________________________ Home / Work / Cell

E-mail Address ____

Social Security # _____________________ Driver's License # ____________ Sex M / F

Emergency Contact ______________________________ Best Phone # _______________

Referring Doctor _________________________________ Phone # _______________

Date of Last MD Visit: Diagnosis _______________________________________

Prescription Frequency & Duration _______________________________________

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

Employment Status Full-Time / Part-Time / Not Working / Retired

Employer _____________________________________ Phone # _______________

Address ____

Injury Type Work / Auto / Home / Other Date of Injury _______________

Area(s) Being Treated ____

Attorney Involved? Yes / No

Attorney Name _________________________________ Phone # _______________

Address ____

PRIMARY INSURANCE INFORMATION

Insurance Carrier ________________________________ Phone # _______________

Insured Name ___________________________________ Insured Date of Birth __________

Relationship to Insured ____

Policy / ID # ___________________________________ Group # _______________

Adjustor's Name (Worker's Comp Only) _________________ Phone # _______________

Claim # ____

Have you had PT, OT, Speech Therapy or Chiropractic this year? Yes / No How many visits? _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier ________________________________ Phone # _______________

Insured Name ___________________________________ Insured Date of Birth __________

Relationship to Insured ____

Policy / ID # ___________________________________ Group # _______________

Pasadena Physical Therapy **MEDICAL HISTORY**

Patient Name ______________________________ **Date of Birth** ______________

Area of Injury/Condition ______________________________

Date of Injury/Onset of Condition ______________ Date of Surgery (if applicable) ______________

Date of Next Doctor's Appointment? ____________

What are your goals for physical therapy?

1. ______________________________
2. ______________________________
3. ______________________________

What is your perceived level of function for the involved body part as of today? _____% (100% = body part is normal)

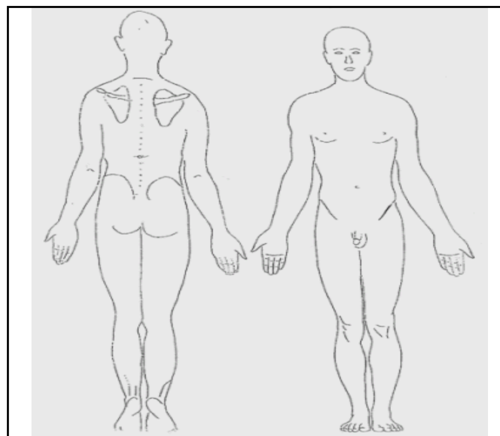
Please describe your pain: ______________________________

____

____

Please rate your pain (1 = minimal, 10 = severe)

At its WORST:	1	2	3	4	5	6	7	8	9	10
At its BEST:	1	2	3	4	5	6	7	8	9	10



Please Mark the Area(s) of Concern

Do you currently have, or have you ever had any of the following?

High Blood Pressure	NO	YES	Osteoporosis	NO	YES	Pain at Night	NO	YES
Heart Disease	NO	YES	Cancer	NO	YES	Leg Swelling	NO	YES
Circulatory Conditions	NO	YES	Arthritis	NO	YES	Asthma	NO	YES
Seizures	NO	YES	Diabetes	NO	YES	Fractures	NO	YES

Have you noticed a significant change (gain or loss) in weight?	NO	YES
Have you noticed a change in your vision or hearing?	NO	YES
Do you have any METAL (pins, plates) in your body?	NO	YES
Do you have a PACEMAKER?	NO	YES
Do you have any allergies?	NO	YES
(Females only) Do you suspect that you may be pregnant?	NO	YES

Please list any recent diagnostic studies (MRI, x-rays, etc.) ______________________________

____

Please list any previous surgeries you have had, please provide dates if possible: ______________

____

____

Please list any medication you are currently taking: ______________________________

____

______________________________ ______________________________

Patient Signature **Date**

Pasadena Physical Therapy — OFFICE POLICY

Patient Name ______________________________

Consent for Care and Treatment

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Pasadena Physical Therapy, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

Pasadena Physical Therapy
615 E. Union St.
Pasadena, CA 91101

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collection moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance.

Cancellation and No-Show Policy

I understand that specific time is reserved for me when I schedule an appointment. If I cannot keep my scheduled appointment, I will provide ***at least 24 hours*** notice so that Pasadena Physical Therapy may reschedule my appointment and offer the reserved time to another patient. ***The charge for a cancellation without prior notice or a no-show is $50.*** I understand that this charge is not covered by insurance and that I will be personally responsible for any cancellation or no-show fees.

Worker's Compensation Claims

I understand that if I claim Worker's Compensation benefits and am subsequently denied benefits, I may be held responsible for the total amount of charges for services rendered to me.

Consent for Treatment of a Minor

As parent and/or legal guardian, I authorize Pasadena Physical Therapy to treat the minor patient named below while I am not present.

- Parent or Guardian Signature ______________________________
- Date ______________________________

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

______________________________ ______________

Patient 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 DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment of 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 Medical 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 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 permissions. 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 record 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 Signature **Date**