Dear New Patient:

Thank you for choosing Palo Cedro Physical Therapy for your rehabilitation needs. As a new patient, we will need you to fill out several forms. This may be done in your home or you may do so at our office. If you choose our office, please arrive approximately 15 minutes early to complete your paperwork. Please complete one of each of the following:

1. PATIENT INFORMATION
2. MEDICAL INFORMATION
3. PRIVACY POLICY
4. QUESTIONAIRE

When you arrive for your physical therapy appointment, please wear comfortable loose-fitting clothing. Please bring shorts if your injury has occurred in the lower extremities. And lastly, bring in your prescription and your insurance card (if applicable).

We are looking forward to working with you in reaching your goals for optimum health.

Thank you,

The Staff at Palo Cedro Physical Therapy

Palo Cedro Physical Therapy

PATIENT INFORMATION

Legal Name: _____ Date of Birth: _____ Age: ___ Sex: M F (circle)

Preferred Name: _____ Height: _____ Weight: _____ _____

(Height and weight required by Medicare)

Primary Phone: _____ Other Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

SS #: _____ Responsible Party: _____

Emergency Contact: _____ Phone:_____

Email Address: _____ Status: Single / Married / Child

Referring Physician: _____ Primary Physician: _____

I authorize Palo Cedro Physical Therapy, and all persons acting as agents therefore, as well as all treatment personnel to furnish all forms of reasonable diagnostic, and therapeutic treatments to me or my minor child/conservatee.

How did you choose our practice?

☐Physician ☐Former Patient ☐Employer ☐Flyer/Mailer ☐Yellow Pages ☐Web Site

☐Friend/Relative; whom: _____

INSURANCE INFORMATION

(Please present insurance card to receptionist to copy)

Primary Insurance: _____ Subscriber's Name: _____

Secondary Insurance: _____ Subscriber's Name: _____

Relation to Patient: _____ Date of Birth: _____ SS#: _____

I hereby give authorization for present and future payments of medical benefits to be made directly to Palo Cedro Physical Therapy (PCPT) for services rendered. I understand that I am responsible for payment of physical therapy services rendered, regardless of whether or not such services are a covered benefit of my insurance. I agree to pay all co-pay and deductible amounts at the time of service unless arranged otherwise. I hereby authorize the release of any medical and personal information necessary to secure the payment of benefits.

As a courtesy to our patients, PCPT will bill your insurance company for you. However it is your responsibility to pay any amount not paid/covered by you insurance. PCPT will add a 10% per annum interest on all 'patient responsible balances' if not paid in full from 30 days past due date. In the event your account becomes seriously delinquent administration fees and interest will be added.

Patient, Parent/Guardian Signature:_____

Palo Cedro Physical Therapy

PHYSICAL THERAPY INTAKE SHEET

Name: _____ Date: _____

Occupation: _____ Age: _____

CURRENT SYMPTOMS

Location (body part):_____ Which side? Left Right N/A

How would you describe your symptoms? _____

(Circle all that apply) Ache Burn Stab Shoot Sharp Numb Pins & Needles Stiffness/Tightness Weakness

When did your symptoms begin and/or what date did your injury occur? _____

Are your symptoms due to a fall/accident/injury? **Y** **N** If ***yes***, briefly described below.

_____

Did you have surgery related to ***this*** incident? **Y** **N** If ***yes***, briefly described below.

_____ Date of surgery: ___/___/___

Did you have any functional limitations prior to this incident? N/A Mild Moderate Severe

CURRENT MEDICATION LIST

Are you currently taking any medication? □ Yes □ No

Medication	Dosage	Frequency	Method

(If additional room is needed, please use reverse side or attach additional sheet)

How do you rate your pain 0 – 10 **(0= no pain,** and **10 = extreme/unbearable pain)**

Current:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Best:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Worst:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Overall: Circle **ONE** face below that indicates your **<u>overall</u>** pain associated with this event

Medical history: Do you **now**, or **ever** had any of the following? **Surgeries: (Please circle/list)**

Shoulder L R Elbow L R Wrist/hand L R Hip L R Knee L R Ankle/foot L R Neck Back

_____

(Circle all that apply) Heart problems Hepatitis HIV/AIDS Diabetes: Type I Type II High blood pressure Cancer Ulcers Parkinson's Multiple Sclerosis Stroke/CVA Pacemaker/Defibrillator

Other: _____

(If additional space is needed, please continue on the back of this page)

Patient, Parent/Guardian Signature: _____

Palo Cedro Physical Therapy

PRIVACY PRACTICE POLICY

Effective date of notice: July 1, 2015

We are committed to protect your healthcare information and will not release information to anyone without your consent. It is standard medical practice to provide your physical therapy evaluation and progress reports to your referring physician(s) and authorization insurance agents. Please list any other people whom we have your permission to discuss your appointment, insurance or medical information. Do we have your permission to release information to anyone other than yourself, your referring physician, and/or authorizing insurance agents?

YES / NO (please circle one and indicate below whom)

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

I have had the opportunity to review and receive the Notice of Privacy Practices. I give my permission to *Palo Cedro Physical Therapy* to use and disclose my health information in accordance with this notice.

Patient, Parent/Guardian Signature: _____ Date: _____