Patient Information Form

Demographics:

Last name	
Middle initial	
First name	
Preferred name	
Date of birth	
SSN	
Gender	
Marital Status	
Employment	
Emergency contact (EC)	
EC phone	
EC relationship	

Address:

Address line 1	
Address line 2	
Zip	
City	
State	

Phone/Email:

Home		Cell	
Work		Phone carrier	
Would you like a reminder text	☐ Yes ☐ No		
Okay to leave confidential message?	☐ Yes ☐ No		
Email			

Primary Insurance:

Plan name	
Relationship to subscriber	
Subscriber	

Member ID	
Group #	
Policy #	
Claim #	

Physician information:

Referring physician	
Date of injury/onset	

Physician phone	
Physician Fax	

Additional Questions:

Auto Related: ☐Yes ☐No	Work Related: ☐ Yes ☐No	Accident Related: ☐Yes ☐No
Attorney Involved: ☐Yes ☐No Name:	Attorney Phone#: Attorney Fax #:	
Post-surgical: ☐Yes ☐No Surgery date:	Surgery Description:	
Have you had any prior physical therapy this year? ☐Yes ☐No If yes, please state when and where:		
Please indicate your current Height and Weight (**REQUIRED**): Height: _____ft_____in Weight: _____lbs		
How did you hear about us? ☐ MD Referral ☐ Family/friend ☐ Internet ☐ Other:_____		

Patient Symptoms

How did the injury occur?

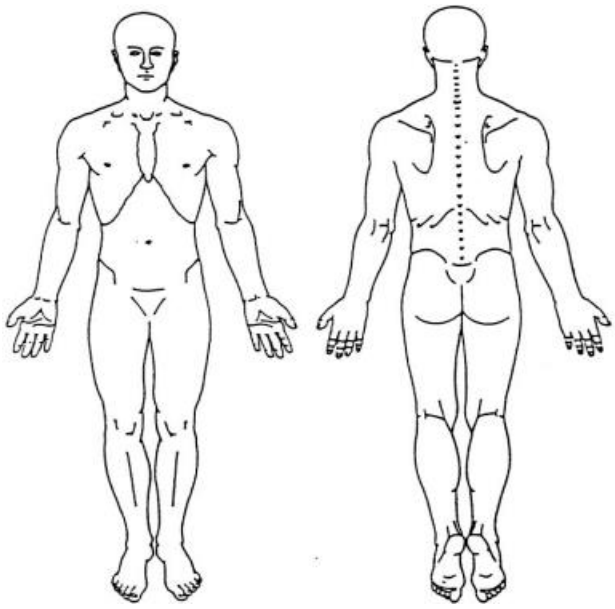
Medications list:

_____
_____
_____
_____
_____

☐ see attached list

Please describe your symptoms:	
What makes you feel better?	What makes you feel worse?
Please rate your pain on a scale of 0-10: 0 No Pain 1 2 3 4 5 Moderate Pain 6 7 8 9 10 Worst Possible Pain	

On the body diagram below, shade in the area(s) where you are having pain, tingling or numbness:



Past/Current Medical History:

☐ Arthritis (rheumatoid / osteoarthritis)
☐ Osteoporosis
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
☐ Angina
☐ Congestive heart failure (or heart disease)
☐ Heart attack (Myocardial infarction)
☐ High blood pressure
☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
☐ Stroke or TIA
☐ Peripheral Vascular Disease
☐ Headaches
☐ Diabetes Types I and II
☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
☐ **Pacemaker**
☐ Seizures
☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
☐ Hearing impairment (very hard of hearing, even with hearing aids)
☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
☐ Kidney, bladder, prostate, or urination problems
☐ Previous accidents:_____
☐ Allergies
☐ Incontinence
☐ Anxiety or Panic Disorders
☐ Depression
☐ Other disorders
☐ Hepatitis, Tuberculosis, HIV, AIDS, or other blood-borne condition
☐ **Prior surgery**:_____
☐ Prosthesis / Implants
☐ Sleep dysfunction
☐ **Cancer**
☐ None of the above

Please indicate the number of surgeries for your primary condition.

None ☐1 ☐2 ☐3 ☐4+

How many days ago did the condition begin?

0-7 days ☐8-14 ☐15-21 ☐22-90 ☐91 days to 6 mos ☐Over 6 mos. ago

Are you taking prescription medication for this condition?

☐Yes ☐No

Have you received treatments for this condition before?

☐ Yes ☐No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

☐At least 3 times a week ☐Once or twice per week ☐seldom or never

Patient Acknowledgement and Consent Form

Authorized Designated Individuals

Please list below the individuals you would like to have access to your private health information. If you would prefer not to designate authorized individuals, PLEASE WRITE "**NONE**" AND SIGN.

Name:	Relationship:
Name:	Relationship:

I hereby authorize these designated parties to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Patient/Guardian Signature:	Date:

Acknowledgement and Consent of Terms and Policies

By signing, I certify that I have read the attached documents "*Notice of Patient Information Practices*" and "*Note to Our Patients Regarding Billing, Payment, and Office Policy*" and furthermore agree to comply with terms of therein. These documents include but are not limited to the following clauses which I have read, understand, and with which I agree to comply:
Because this is a small private business, late cancellations and failed appointments affect us greatly and we adhere to our cancellation policies.

1. "I understand that cancelling my appointment with less than 24 hours of notice or failing to keep my appointment will result in a **$75 fee**, to be paid by me personally, NOT by my insurance!"
2. "My copayment or out-of-pocket payment is due at the time of service. If I do not pay at the time of service, a **$25 billing fee** will be added to my balance on each statement mailed out to me.
3. For my convenience, PTI accepts all major credit cards as well as personal checks. A **$50 fee** will be charged for any bounced checks.
4. PTIs fee for medical records when released to the patient is **$50**. When requested by any other party (lawyers, non-referring MDs, etc) the **fee is $75**. These fees are non-negotiable.
5. Accounts that are delinquent past 90 days will be automatically submitted to collections for payment. If we have to send your account to collections, there will be an extra fee added to your balance. Once in collections we are unable to reduce/void any fees. Please note: collection agency has their own interest rates that they add to your account balance.

PTI provides text and email reminders as a courtesy, but it is **MY RESPONSIBILITY** to attend my appointment in the event of no reminder. **Please NOTE: you can not reply to email or text reminders you must call in (voicemail is available after hours)**

I understand that Physical Therapy Innovations may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that copayment and deductibles are due at the time of service, except pool therapy copayments, which I may pay in advance or have billed to me. I authorize the participation of PT and PT assistant graduate candidates in my treatment. I understand that I am ultimately financially responsible for any services provided by Physical Therapy Innovations, Inc. By signing below, I agree that I have been given a copy of the full list of PTI policies to keep as a reference.

Patient/Guardian Signature:	Date:

Assignment and Release

I authorize my insurance benefits be paid directly and mailed to: **Physical Therapy Innovations, Inc. 425 Kearney St. El Cerrito, CA 94530**. If my policy prohibits direct payment to the health provider, then I hereby also instruct my insurance company to make the check out to me but **mail it in care of Physical Therapy Innovations, Inc**. I understand I am responsible for any amount not covered by my insurance, and for any costs incurred for collection on my account. I authorize Physical Therapy Innovations, Inc. to furnish information concerning my illness and treatments to my insurance carriers. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient/Guardian Signature:	Date: