PILLSBURY PHYSICAL THERAPY

6678 Clark Rd
Paradise, CA 95969
Tel: 530.876.1006.
Fax: 530.876.8225

2623 Forest Ave
Chico, CA 95926
Tel: 530.343.2778
Fax: 530.343.2738

PATIENT INFORMATION

Last Name: ______________________________ First Name: _____________________________ MI: ________
Gender: ○ Male ○ Female Birthdate: _____/_____/_____ Age: _____ Marital Status: ___________________
Address: ____
City: _______________________________________ Home Phone: __________________________________
State: __________________ Zip ______________ Cell Phone: __________________________________
Email: ____ Best # to reach you? ○ Home ○ Cell
Social Security: _________-_______-_________
What is your preferred form of communication? ○ Phone ○ Text ○ Email

Emergency Contact:
Name: _____________________________ Phone: (_____) _______________ Relationship: _________________________
I give permission to discuss my medical information with the following**:**
Name____ Relationship______________________________________
Name____ Relationship______________________________________

Referring Physician: _____________________________________ Phone:____
Family Physician: _____________________________________ Phone:____
Employment Status: ○ Employed ○ Retired ○ Unemployed

INSURANCE INFORMATION

Primary Insurance: __________________________ Insured: ○ Self ○ Other
Secondary Insurance: ________________________ Insured: ○ Self ○ Other
If other, name insured: ____________________________ Relationship: ___________________ DOB: _____/_____/_____

Are you currently enrolled in home health? ○ yes ○ no

Have you received Physical Therapy already this year? ○ yes ○ no

Date of Injury/Onset of Symptoms: _____/_____/_____
Type of Injury: ○ Work ○ Auto ○ Other
Attorney Involved: ○ yes ○ no
Name of Attorney: _____________________ Phone: (_____) _____________

Other than your doctor, how did you hear about us?
Patient Friend/Family Yellow Pages Beyond Fitness Member Website Other: _______________

Patient Signature____ Date______________________________

NOTICE OF PRIVACY POLICIES

(Effective September 1, 2013)

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 Operation:** 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 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 worker's 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 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 facility or law enforcement official. **For Marketing Purposes:** Any uses or disclosures of your health information for marketing purposes, or disclosures that constitute a sale of your protected health information, will require your direct authorization prior to action. **Regarding Genetic Information:** We are prohibited from using or disclosing your protected health information that contains your genetic information for any underwriting purposes. **Other disclosures not listed above:** Any uses or disclosures not described above will be made only with your direct authorization.

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 Disclosers:** You have the right to request in writing, a list accounting for any disclosers of your medical information we have made, except for uses and disclosers 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. **Your Right to Restrict Disclosures:** You have a right to restrict certain disclosures of your personal health information to your health plan regarding services that you pay out of pocket in full for (self-pay). **You're Right to Notification of Breaches:** If your personal information is affected by a breach of security at one of our clinics, you have a right to be notified of said breach, as well as the details surrounding the breach.

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 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**

Pillsbury Physical Therapy, Inc. Medical Screening Form

Name: ____ **Date of Birth:**________________ **Date:**____________

Age: _____ **Height:** ______ **Weight:** ______

Do you use tobacco? **Yes** **No**
Do you have a pacemaker? **Yes** **No**
Are you under any abnormal stress? **Yes** **No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **Yes** **No**
ALLERGIES: List any medication(s) you are allergic to: ____
Leisure activities, including exercise routines: ____

Occupation and activities: ____________________________________
Are you on a work restriction from your doctor**?** **Yes** **No**

Please indicate if you are having any difficulty with: Hearing / Speech / Vision / Communication

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Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ unexplained weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ trauma of any kind
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ recent infection
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency
- ❑ depression
- ❑ lung problems
- ❑ gastrointestinal problems
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ osteoarthritis
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ pneumonia
- ❑ hepatitis
- ❑ liver problems

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ diabetes
- ❑ high blood pressure

During the past month have you been feeling down, depressed or hopeless? **Yes** **No**
During the past month have you been bothered by having little interest or pleasure in doing things? **Yes** **No**
Is this something with which you would like help? **Yes** **Yes, but not today** **No**

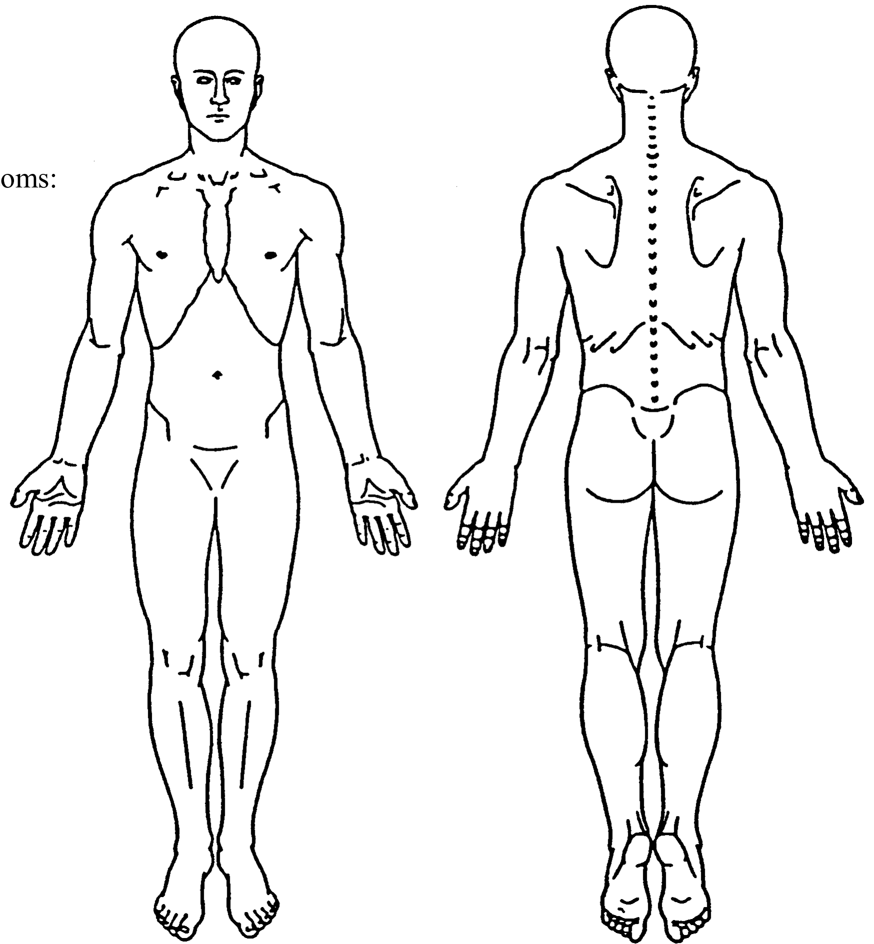
Have you ever taken steroid medications for any extended period of time? **Yes** **No**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**
Are you currently taking any medication for pain? **Yes** **No**

Have you experienced any falls in the past year? **Yes** **No**
Were you injured? **Yes** **No**
If you have fallen, how many times have you fallen in the past year? _________

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting pain**
X Sharp pain
O Dull/aching pain
/// **Throbbing pain**
||| **Numbness**
= **Tingling**



Please list any surgeries, including dates:

1. ______________________

2. ______________________

3. ______________________

My symptoms currently**: Come and go** / **Are constant** / **Are constant, but change with activity**

What date (approximately) did your present symptoms start? ____

What do you think caused your symptoms? ____

My symptoms are currently: **Getting Better** / **Getting Worse** / **Staying about the same**

I should not do physical activities that might make my pain worse**: Disagree / Unsure / Agree**

Prior to the onset of your current symptoms, were you limited with any of your usual activities? **Yes No**

Treatment received so far for this problem (chiropractic, injections, etc) _______________________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc) ______________________________

Have you ever had this problem before: **Yes No** When__________ Treatment rec'd__________________

I would rate my overall health as: **Excellent / Good / Fair / Poor**

For Staff: Last Name: __________________ Date of Birth: ______________

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 **Pillsbury Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR CARE & TREATMENT OF A MINOR: As parent and/or legal guardian (choose one) of ___________________________________, (patient's name) I understand that a Physical Therapist will complete an evaluation by examination and interview. An 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 **Pillsbury Physical Therapy, Inc**. to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating the minor listed above while I am not present.

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

ASSIGNMENT OF <u>MEDICARE BENEFITS</u> & RELEASE OF INFORMATION: By signing below, I request that payment of authorized Medicare benefits be made on my behalf to: **Pillsbury Physical Therapy, Inc.** for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF SECONDARY INSURANCE BENEFITS (medi-gap) **& RELEASE OF INFORMATION**: By signing below, I request that payment authorized medi-gap benefits be made on my behalf to **Pillsbury Physical Therapy, Inc**. for any services furnished to me by this provider. I authorize any holder of medical information to release to: ____ (name of secondary insurer) any information needed to determine these benefits or the benefits payable for related services.

WORKER'S COMPENSATION CLAIMS: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. We require that arrangements for payment of your estimated share of cost be made today. <u>You are responsible for your bill</u>. 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 collection 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 and you agree to pay your portion of this bill. We assume no liability for any errors made by your insurance carrier in this quotation.

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

____ Date: __________________________________

Patient / guardian / Responsible Party

____ Date: __________________________________

Clinic Representative

Appointment Cancellation and No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, we ask that you call at least **24 hours** prior to your scheduled appointment if you are unable to attend. This allows the ability to offer that appointment time to another patient.

Failure to keep your scheduled appointment may result in a **$75.00** fee. This fee cannot be billed to your insurance company. This fee will be your responsibility.

We understand that delays can happen, however we must try to keep other patients and therapists on time. **If a patient arrives more than 15 minutes late past their scheduled appointment time, we may have to reschedule the appointment.**

Patients who do not show for their appointment without calling to cancel will be considered as a **NO-SHOW.** Patients who no-show for two (2) or more visits in a 12 month period may be dismissed from the practice. If there are any appointments scheduled after the 2 no show appointments, we may cancel any future visits that were scheduled.

Thank you for your understanding and compliance to our appointment cancellation and no show policy.

I understand Pillsbury Physical Therapy's appointment and cancellation policy and my financial responsibility.

____ __________________________

Patient Signature Date