SALINAS
Physical Therapy/ Sports Medicine

NEW PATIENT FORM

PRINT CLEARLY

Date:_____

Name (First)_____(Last)_____ (M.I.) _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Other Phone_____

Social Security_____ Birthdate_____ Age _____ Sex: M / F

Drivers Lic #_____ Email Address_____

Emergency Contact_____ Telephone_____

Doctor _____ Telephone _____

Address _____

How did you hear about us?

☐ Doctor Referral (Dr. Name) _____ ☐ Friend/Relative (Name) _____

☐ Insurance ☐ Our Website ☐ External Sign ☐ Yelp / Social Media

Employer_____ **Employment** Full / Pt-time / Not Working / Retired

Address_____Phone_____

Relationship status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____Injury Date _____

Area(s) Being Treated:_____

Claim / Authorization / Referral # _____Lawyer Involved Yes / No

Attorney name _____ Telephone # _____

Address_____

Primary Insurance_____

Insured Name _____Social Sec# _____D.O.B._____

Secondary Insurance_____

Insured Name_____Social Sec#_____D.O.B._____

Patient Signature:_____**Date:**_____

SALINAS
Physical Therapy/ Sports Medicine

MEDICAL HISTORY

Patient Name_____ Age_____

Type of Injury / Condition _____

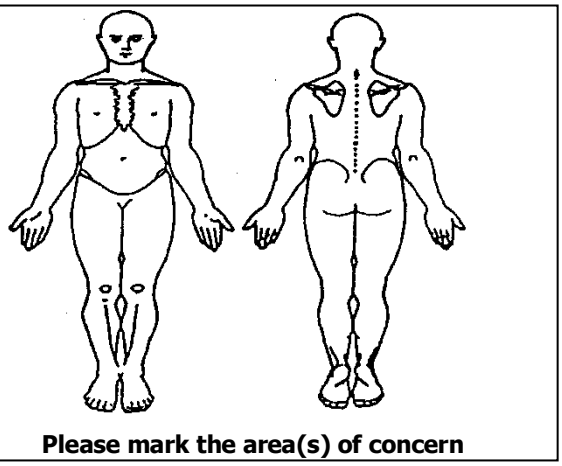
Onset / Injury Date_____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition_____

_____



Please mark the area(s) of concern

Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently experienced:

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision or Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Osteoporosis
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Have you suffered any falls in the last year? How many? _____

Explain & give approximate dates for any items indicated above_____

_____

Do you smoke? Yes / No / Past smoker

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

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?_____

_____

What are your physical or fitness goals: _____

_____

SALINAS
Physical Therapy/ Sports Medicine

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 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**

SALINAS
Physical Therapy/ Sports Medicine

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Salinas Physical Therapy/Sports Medicine Center** 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 **Salinas Physical Therapy/Sports Medicine Center** 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 **Salinas Physical Therapy/Sports Medicine Center** 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. The charge for cancellation without proper notice is $25 for physical therapy visits. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

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 the bill.

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

_____

PATIENT/Responsible Party **Date**

SALINAS
Physical Therapy/ Sports Medicine

Direct Physical Therapy Treatment Services Disclosure

(Effective January 1, 2014)

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Your physical therapist is a professional employee, partner, or owner in this physical therapy practice, which will bill your insurance company and/or the patient for professional physical therapy services recommended and administered by the PT only in the best interests of your personal health.

Under California law, you may continue to receive direct physical therapy treatment services *for a period of up to 45 calendar days or 12 visits*, *whichever occurs first*, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving a dated and signed treatment plan from a licensed physician, surgeon, or podiatrist indicating approval. The plan can only be approved following an in-person patient examination and evaluation by the physician, surgeon or podiatrist.

_____ _____

Patient or Guardian Signature **Date**