Spring Physical Therapy

5120 Manzanita Ave, Suite 110
Carmichael, California 95608
Phone: (916) 926-0496
Fax: (916) 248-7477

PATIENT INFORMATION FORM

Please complete ALL items. If an item does not apply, put N/A

Patient Name: _____ D.O.B. _____
Last First Middle

Address: _____
Street City State Zip

Primary Phone: _____ Secondary Phone: _____

Appointment reminder preference: Text/Call/None

Gender: Male/ Female Marital Status: _____ Social Security #: _____

Email Address: _____

Referring Doctor: _____ Phone: _____

Person to notify in case of EMERGENCY:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____
Street City State Zip

Medical History:

Have you been treated here or by another physical therapist previously? Yes ____ No ____

If yes, where? _____ When? _____

Was it for the same condition? Yes ____ No ____

HAVE YOU RECENTLY RECEIVED ANY TYPE OF HOME HEALTH ? Yes ____ No ____

Name of Home Health Agency: _____

*If you have **not been formally released from home health** OR **are currently receiving home health**, please be aware that insurance will not cover both services*

PRIMARY Insurance Company: _____

Policy Holder's Name: _____
Last First Middle

Is there a secondary Insurance? Yes ____ No ____

Name of Secondary Insurance Company _____

****

IS THIS A WORKER'S COMPENSATION CLAIM ? Yes ____ No ____

****

IS THIS AN ACCIDENT CASE ? Yes ____ No ____ VEHICLE ____ Other_____

****

Financial Policy

I hereby agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances an extended payment plan may be arranged through our billing department, If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Spring Physical Therapy (SPT). I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, AUTO, ETC.), then I am financially responsible and agree to pay for all the charges related to services provided to the patient at SPT. In the event that services deemed medically necessary by your physical therapist are not covered, not authorized or deemed not medically necessary by my Health Plan, then I, the member, will be held financially responsible and agree to pay for all the charges related to the services provided by SPT.

Although I have requested Spring Physical Therapy to bill my insurance company on my behalf, I clearly understand that I am responsible to SPT for payment on my account regardless of the status of my insurance claim.

I hereby authorize Spring Physical Therapy to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

INFORMED CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of therapeutic procedures, to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. (Therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics;modalities such as heat, ice, e-stim, and ultrasound; and special procedures such as taping.) All procedures will be thoroughly explained to you before you are asked to perform them. Individuals will be accorded impartial
access to treatment regardless of race, gender, national origin, disability, health status, religion, age, sexual orientation, or sources of payment for care.

Response to physical therapy intervention varies from person to person so it is not possible to predict your response to a specific modality, procedure, or exercise protocol. Spring Physical Therapy cannot and does not guarantee what your reaction will be to a specific treatment. Potential benefits of treatment may include an improvement in symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in movements and a decrease in pain or discomfort. However, there are potential risks that the physical therapy treatment may cause: you may experience an
increase in your current level of pain, or discomfort or result in aggravation of existing systems, pain, or injury. It is very important for you to promptly provide any updates about your medical condition(s) and to communicate with your treating physical therapist throughout your treatment.

You may decline any part of your treatment at any time before or during treatment if you feel any discomfort or pain or have any other unresolved concerns. You may ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results, and you may discuss potential risks and benefits involved in your treatment. The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment
have been explained to you. You understand that the physical therapist provides a wide range of services and you will receive information at the initial visit concerning the proposed treatment and options available for your condition.

By signing below, I have read this consent form and understand the risks involved with physical therapy care treatment. I voluntarily assume all of the foregoing risks and accept full responsibility for any loss, property damage, illness or exposure to illness, or personal injury, that may be sustained by me or my property as a result of my receiving such physical therapy care and treatment. I hereby give consent for Spring Physical Therapy to furnish such care and treatment considered necessary and proper in treating my physical condition.

I certify that I have read and understand the above consent statements:

Patient’s Signature: _____ Date: _____

Parent or AuthorizedRepresentative (if applicable): _____

PATIENT MISSED APPOINTMENT POLICY

We request that you keep all of your appointments, with the exception of serious emergencies. If you need to reschedule an appointment we require a notice at least 24 hours in advance. As soon as you are aware of a conflict with your appointment, please call the office immediately and leave a message.

In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $ 50.00 fee. **If you arrive after your appointment is scheduled to begin, no additional time will be added to the end of your session to compensate for lost tim**e.

Repeated instances of non-compliance with your scheduled visits, (2 no-shows or 3 same day cancellations) may result in the discontinuation of physical therapy) and we will inform your physician of the fact that you were discharged due to non-compliance with the prescribed rehabilitation order.

Your adherence to this policy enables us to continue to offer optimal treatment times for you and all of our clients.

Please sign below in acknowledgment of this policy.

Patient's Signature: _____ Date: _____

Parent or AuthorizedRepresentative (if applicable): _____

HEALTH HISTORY

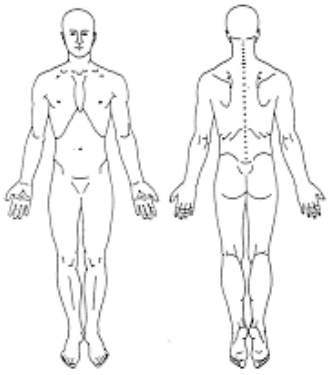
Name: _____ Age: ___ Gender: ___ Height: ____ Weight: ____
Occupation: _____ Date of Injury: _____ DOB: _____

1) Do you have any of the following medical conditions? Please Circle
   - Yes No Heart Problems
   - Yes No Pacemaker /Afib
   - Yes No High Blood Pressure
   - Yes No History of Stroke
   - Yes No Asthma
   - Yes No Diabetes
   - Yes No Numbness or tingling in arms or legs
   - Yes No Cancer
   - Yes No Infection, please describe_____
   - Yes No Recent fractures (broken bones) if so please list _____
   - Yes No Serious Injury, explain_____
   - Yes No Major surgery, type_____
   - Yes No Medical Allergies, if so please list _____
   - Yes No Epilepsy _____
   - Yes No Headaches, type_____

2) List any other history or medical conditions or illnesses:
   _____

3) What medication(s) are you currently using? (include dosage and frequency):
   _____

4) Please indicate on the diagram below that location of your pain and describe the type of pain (sharp, dull, aching, shooting, etc.)



HEALTH HISTORY CONTINUED

5) How did the injury occur? (Please be specific)_____
_____

6) Did you have surgery for this injury, and describe what type and the date of surgery?
_____
_____

7) Please rate your pain below by choosing a number from the Pain Scale which represents your pain at its lowest, average, and highest:

PAIN SCALE
0-No Pain
1-2 Mild
3-4 Discomforting pain/which may be ignored
5 Discomforting pain/which may be distracted
6 Distressing pain, but able to perform tasks
7-8 Intolerable pain, concentration is difficult/able to perform some tasks
9-10 Intolerable pain and hospital care is required

8) Is your pain getting better? _____ worse?_____ same?_____

9) Have you already received treatment for this problem at other locations?
Please circle/the following:
Medical Doctor Yes No
Chiropractor Yes No
Physical Therapist Yes No
Other _____

10) What test(s) or treatment(s) have you had concerning this problem?
Please check.
_____X-ray _____ Myelogram
_____CT Scan _____ Cortisone Injections
_____ MRI _____ Biofeedback
_____ EMG
_____ Other, please explain

11) Are you currently working? Yes No
If no, last day worked: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

To ensure you receive the best quality care, staff at Spring Physical Therapy must speak with other medical
professionals and/or personal contacts involved in your care. If there are any other individuals who may be involved in your care that you would like Spring Physical Therapy to be able to communicate with, please list those individuals below:

Examples include family, friends, caregivers, secretaries, transportation company etc.

1) _____

2) _____

3) _____