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

PATIENT INFORMATION FORM

Please complete ALL fields. If a field does not apply, put N/A

Patient Name:____ DOB:________________

Last First Middle

Has your address changed since your last visit?

☐ **No** ☐ **Yes**: ____

Street City State Zip

Primary Phone:_________________________ Secondary Phone:_________________________

Appointment reminder preference: ☐ **Text** ☐ **Call** ☐ **None**

Insurance Information:

Has your insurance changed since your last visit?

☐ **No** ☐ **Yes**, new plan/ID #____

****

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ **Yes** ☐ **No**

****

IS THIS AN ACCIDENT CASE? ☐ **Yes ↓** ☐ **No**

Attorney's Office/Representative:____

Ph #_________________ Fax #_________________ Email:______________________________

Acct # ____________

HEALTH HISTORY

Name:	DOB:	Age:	Gender:

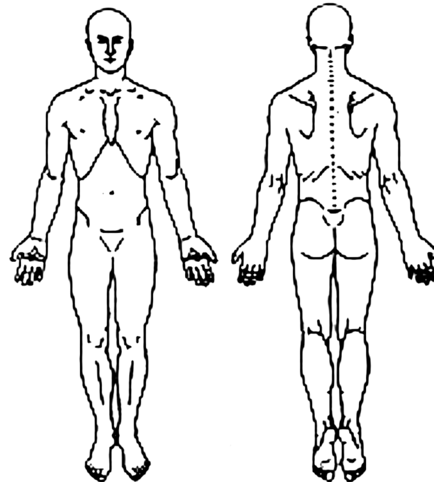
Height:	Weight:	Occupation:	Injury Date:

1. Do you have any of the following medical conditions (check all that apply)?

☐ Heart Problems ☐ Headaches ☐ Recent fractures ☐ Major surgery
☐ Pacemaker/Afib ☐ Infection ☐ Serious injury ☐ Medical allergies
☐ High Blood Pressure ☐ Asthma ☐ Epilepsy ☐ Numbness/tingling in arms/legs
☐ History of Stroke ☐ Diabetes ☐ Cancer
☐ Pregnancy ☐ Other (please specify):________________

0	1-2	3-4	5	6	7-8	9-10
No pain	Mild pain	Discomforting pain, may be ignored	Discomforting pain, may be distracted	Distressing pain, but able to perform tasks	Intolerable pain. Concentration is difficult, but able to perform some tasks	Intolerable pain, hospital care is required

2. Please rate your pain on the scale above ↑. Circle the location of your pain on the diagram below ↓



3. How did the injury occur? (Please be specific)____

____

4. Did you have surgery for this injury (if yes, what type and the date of surgery)? ___________________

____

5. Is your pain getting better? _______ worse? _______ same? _______

6. Have you already received treatment for this problem from other providers (check all that apply)?

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:___________________

7. What test(s) or treatment(s) have you had concerning this problem (check all that apply)?

☐ X-ray ☐ CT Scan ☐ MRI ☐ EMG ☐ Myelogram
☐ Cortisone Injections ☐ Biofeedback ☐ Other:______________________________

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 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 Authorized Representative (if applicable): ____

MISSED APPOINTMENT POLICY

Our goal is to provide quality health care to all our patients in a timely manner.
No-shows, late arrivals, and cancellations prevent other patients from getting much-needed treatment.

APPOINTMENT CANCELLATION:
When you book your appointment, you are reserving a space on our schedule that is no longer available to our other patients. As soon as you are aware of a conflict with your appointment, please call **(916) 926-0496.**

LATE CANCELLATIONS/NO-SHOWS:
A cancellation is considered late when the appointment is canceled or rescheduled **less than 24 hours** before the appointed time (even if rescheduled to a different time for the same day). A no-show is when a patient misses an appointment without canceling.
We reserve the right to charge you a $50.00 fee for late cancellations/no-shows.

If you **no-show** for an appointment, we reserve the right to cancel all prescheduled appointments.

LATE ARRIVAL:
If you are late for your appointment, you may need to reschedule your visit, which will be counted as a short-notice cancellation.

NON-COMPLIANCE:
Your adherence to the recommended treatment sessions is a vital component of your progress in physical therapy. Repeat instances of **non-compliance with your scheduled visits will result in the discontinuation of physical therapy** and we will inform your referring provider that you were dismissed due to non-compliance with the prescribed rehabilitation order.

Please sign below in acknowledgment of this policy.

Patient's Signature: ____ Date: ____________________

Parent or Authorized Representative (if applicable): ____

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 my 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): ____

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) ____