

# FOOTHILL RANCH PHYSICAL THERAPY

# NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: \_\_\_\_\_

Name Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Complaint/ Area to be treated \_\_\_\_\_ Email Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Drivers Lic # \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Injury Date \_\_\_\_\_ Other Phone (\_\_\_\_\_) \_\_\_\_\_ Date First Consulted \_\_\_\_\_

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

**Employment** Full / Part-time / Not Working / Retired **Employer** \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ Telephone \_\_\_\_\_

Who may we thank for your referral other than your Doctor? \_\_\_\_\_

**Injury Type**  Work  Auto  Home  Other \_\_\_\_\_ Lawyer Involved Yes/ No

Attorney name \_\_\_\_\_

Address \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## (OFFICE USE ONLY)

02/28/06

**Primary Insurance** \_\_\_\_\_

Insured Name \_\_\_\_\_ Social Sec# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Relation to Patient Spouse / Child / Other

**Secondary Insurance** \_\_\_\_\_

Insured Name \_\_\_\_\_ Social Sec# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Relation to Patient Spouse / Child / Other

Referring Dr. Address \_\_\_\_\_ UPIN # \_\_\_\_\_

Area(s) Being Treated: \_\_\_\_\_

Diagnosis Code \_\_\_\_\_ Description: \_\_\_\_\_

**Financial Class:** CASH COMMERCIAL INSURANCE MC LIEN W/C HMO

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Type of Injury / Condition \_\_\_\_\_

Onset / Injury Date \_\_\_\_\_

Type of Surgery & Date \_\_\_\_\_

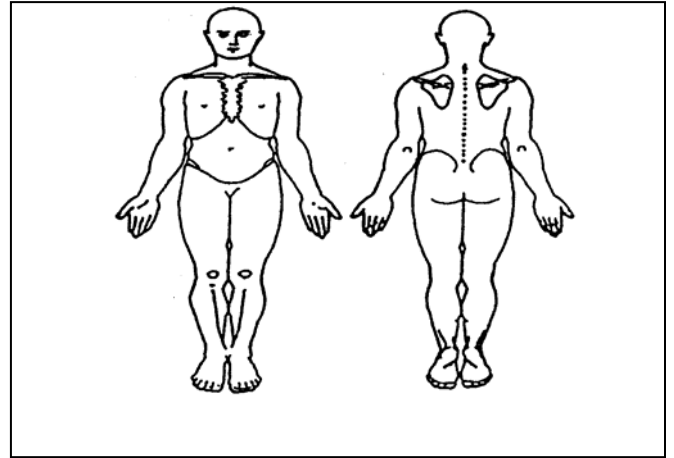
Next Doctor's Appointment? \_\_\_\_\_

Describe previous treatment for this condition \_\_\_\_\_

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



**Have you had any imaging performed:**

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

**Please mark the area(s) of concern**

**Have you recently noted:**

- 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
- Any previous injury that may affect current care \_\_\_\_\_
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Explain & give approximate dates for any items indicated above \_\_\_\_\_

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: \_\_\_\_\_

Is there anything else you would like to include or ask your physical therapist? \_\_\_\_\_

**Patient or Personal Representative Signature**

**Date**

## Foothill Ranch Physical Therapy

### **Acknowledgement of receipt of Foothill Ranch Physical Therapy's Health Information Privacy Notice and Agreement of Acceptance**

I acknowledge that Foothill Ranch Physical Therapy has supplied me with a copy of their health information privacy notice regarding their policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to Foothill Ranch Physical Therapy to use my PHI as deemed necessary for treatment, billing, etc.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## ***Cancellation/Scheduling Policy***

If you need to cancel one or more of your previously scheduled appointments, please give us twenty-four (24) hours notice.

Please communicate other scheduling needs to the front desk personnel. The opportunity for miscommunication increases when you speak to other staff members regarding both your cancellation(s), scheduling, and/or rescheduling of your appointments. Should you fail to make appointments and still show up for treatment, be advised that you may not be seen. However, with the therapist's approval, you can be seen at their convenience.

Due to the high demand for appointments during peak hours of the day, we need your cooperation if you are not able to keep your scheduled physical therapy appointment. For that reason, if you fail to cancel or just do not show up for your appointment, you will be charged \$25 for that day.

Your doctor has requested a report from your physical therapist informing him or her of your status. To help us comply with your doctor's request, please let your therapist(s) know at least one week in advance when you are scheduled to see your doctor.

Should you have any questions regarding this policy, please do not hesitate to let us know.

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Patient/Guardian

Date

**CONSENT FOR TREATMENT OF A MINOR:** As parent and/or legal guardian, I authorize **Foothill Ranch Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

**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 **Foothill Ranch Physical Therapy** 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 **Foothill Ranch Physical Therapy** 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.

**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 a physical therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date

**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 this bill.

Co-Pay	Co-Insurance
<input type="checkbox"/> <b>Estimated</b> Co-Pay \$ _____/visit Deductible \$ _____/year  <input type="checkbox"/> Will pay each visit  <input type="checkbox"/> Will pay weekly in advance	<input type="checkbox"/> <b>Estimated</b> Co-Insurance \$ _____/visit Deductible \$ _____/year  <input type="checkbox"/> Will pay portion of deductible each visit  <input type="checkbox"/> Please bill me for deductible  (You will be billed for your co-insurance amount.)

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

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Representative

\_\_\_\_\_  
Date

09/08/04