



PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: ()	Mobile Phone: ()	Work Phone: ()	
Employer:	Occupation:		
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
Work Address:	City:	State:	Zip:

SPOUSE INFORMATION

Spouse's Name:	Spouse's DOB:
Spouse's Employer:	Spouse's Work Phone: ()

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: () -
Regular Dr./PCP	Regular Dr./PCP Phone: () -
Chose Clinic Because/Referred to Clinic By <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:	

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Please Circle Insurance/Payment Type: <input type="checkbox"/> Work Comp <input type="checkbox"/> Auto <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Cash	Birth date : / /
Primary Insurance Name:	
Subscriber's Name (If different):	Group/Policy #
ID. #:	
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	Birth date : / /
Subscriber's Name:	Group/Policy # ID. #:
Subscriber's Employer	
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:	Phone:	Ext.:
Adjuster/Claim Manager:	City	State: Zip:
Address:	Accident Date: / /	Cause:
Claim #:		

ATTORNEY INFORMATION

Law Firm:	Phone: () -
Name:	City State: Zip:
Address	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):	Home Phone: () -	Work Phone: () -
Relationship to Patient:		

I authorize my insurance benefits be paid directly to Practice Name. I understand that I am financially responsible for any balance. I also authorize _____ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE _____ DATE: _____



North County & Escondido Physical Therapy, Inc.

Patient Medical History Form - For Clinic Use ONLY

Patient Name (Last, First, Middle):	Age:	Date of Birth:	Today's Date:
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Referring Physician (First and Last Name)	Phone Number:
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Primary Care Physician (First and Last Name)	Phone Number:
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Do you have any of the following general medical conditions?

Anemia/Blood Disorders	Yes	No	Bowel/Bladder Incontinence	Yes	No
Asthma, Bronchitis, or Emphysema	Yes	No	Dizziness/Vertigo	Yes	No
Dermatological Conditions	Yes	No	Motion Sickness	Yes	No
Diabetes	Yes	No	Falls	Yes	No
Gastrointestinal Conditions	Yes	No	Osteoarthritis	Yes	No
Gout	Yes	No	Osteoporosis/Osteopenia	Yes	No
Liver/Kidney Conditions	Yes	No	Rheumatologic Disorders	Yes	No
Lung Disorders	Yes	No	Vision/Hearing difficulty	Yes	No
Neurological Disorders/Peripheral Neuropathy	Yes	No	Multiple Sclerosis	Yes	No
Thyroid Conditions	Yes	No	Seizure Disorder	Yes	No
Chlorine Allergy	Yes	No	Cancer	Yes	No
Immunologic Conditions/Allergies	Yes	No	Fibromyalgia	Yes	No

Infections:	Cardiovascular Conditions:
Bone/Joint Infection	Arterial Blockage of the Legs
Chronic Urinary Tract/Kidney Infection	Deep Vein Thrombosis (DVT)
Pneumonia	Heart Conditions (please list)
Viral Conditions	High Blood Pressure/Hypertension
Open Skin Wounds	Stroke/TIA
Other (please list)	Other (please list)

Surgeries and/or Hospitalizations	Other Conditions
1. _____ Date: _____	1. Recent, unplanned weight loss? Yes No
2. _____ Date: _____	2. Unexplained, night pain? Yes No
3. _____ Date: _____	3. Fever or night sweats? Yes No
4. _____ Date: _____	4. Nausea/Vomiting? Yes No
5. _____ Date: _____	5. Unexplained weakness or fatigue Yes No

Medications(use back of page if needed)	Freq.	Dosage		Freq.	Dosage
1. _____			3. _____		
2. _____			4. _____		

Health Related Habits	Ice Sensitive	Yes	No
Do you smoke?	Heat Sensitive	Yes	No
If yes, packs per day?	Are you pregnant?	Yes	No
Number of years smoked?	If yes, what week?		

Previous physical therapy treatment?	Yes	No	
Where and why?			

SWIMMING SKILLS ARE NOT NECESSARY TO PARTICIPATE IN AQUATIC THERAPY!

Do you know how to swim?	Yes	No	
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I will advise my therapist if there is any change in my physical condition or medications which may alter my response to any of the questions on this form and/or my ability to participate in physical therapy.

Signature of Patient, Parent, Guardian, Personal Representative:	Date:
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NORTH COUNTY & ESCONDIDO PHYSICAL THERAPY, INC.
ORTHOPAEDIC & SPORTS REHABILITATION

Name: _____

Date: _____

Please answer the questions below to help us better understand your symptoms.

1. Was there an injury that caused your symptoms? If yes, please describe.

2. Please indicate on the body diagram where your symptoms are.

3. How long have you had your current symptoms that we are treating you for?

4. What activities, movements, and/or positions make your symptoms worst? And for how long?

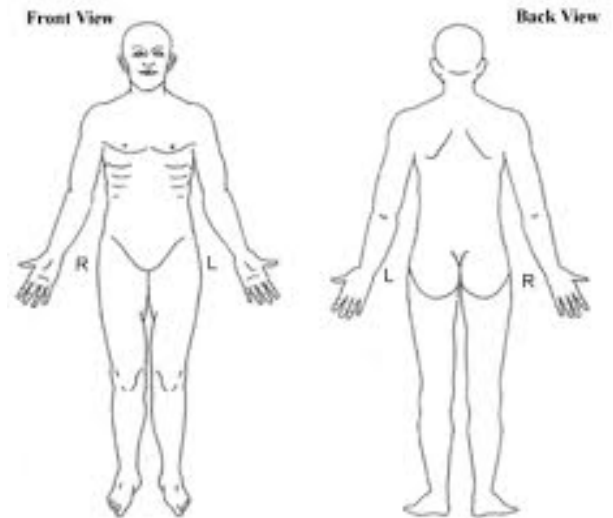
5. What activities, movements, and/or positions make your symptoms feel better? And for how long?

6. Have you received any other treatment for the areas we are treating you for? If yes, please describe the treatment and when you received it.

7. Are your symptoms generally staying the same, getting better, or getting worse?

8. With respect to sleeping, does your pain prevent you from being able to fall asleep and/or does the pain wake you at night?

9. What activities are you not able to do because of your pain? What activities are you trying to get back to doing (recreational and/or normal activities of daily living)?





FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your physical therapy provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. All patients are required to read and sign this policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our front office.

If you have an **HMO INSURANCE PLAN** and we are a contracted provider, your deductible and co-payments will be due at the time of service.

If you have a **PPO INSURANCE PLAN** that covers less than 100%, you are responsible for deductible and coinsurance as you establish a balance. After payment has been applied to your percent due, we then ask that you pay any additional money owed to us on a weekly basis. If you have not met your deductible, payment in full for each visit will be required until your deductible has been satisfied.

If you have dual insurance coverage we will bill both insurances and then will bill the patient for any balance not covered by insurance companies.

If you are using your Auto Insurance medical benefits, please inform us of your med-pay limit.

As a courtesy to you, we will bill your insurance company and will accept assignment of insurance benefits. However, you must understand that:

- 1. Your insurance policy is a contract between you and the insurance carrier. All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts.*
- 2. If your insurance company does not pay within 45 days, we ask that you contact the carrier to speed things up.*
- 3. If your insurance company does not pay within 60 days, we require you to pay the balance due with cash, check, MasterCard, or Visa.*

For **CASH PAYING PATIENTS** we offer a 10% cash discount if paid at the time of service.

MEDICARE PATIENTS. Medicare pays for reasonable and necessary services. Services given to Medicare patients must be within 30 days of the date of the Doctor's referral. Medicare does not pay for medical supplies. If you wish to purchase a supply, you will be asked to pay for the supply at the time of service.

PLEASE SIGN BELOW

I authorize North County & Escondido Physical Therapy to furnish my Insurance Co. and other physicians, as directed, with all information which they may request concerning my present illness or injury. I authorize payment of medical benefits to North County & Escondido Physical Therapy for services provided to me.

I have read and understand this Financial Policy.

Signature _____ Date: _____

North County & Escondido Physical Therapy (NCEPT)
NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

NCEPT's LEGAL DUTY

NCEPT is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

NCEPT uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, NCEPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

NCEPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, NCEPT's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

NCEPT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. NCEPT will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that NCEPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on NCEPT's health information practices or if you have a complaint, please contact the following person:

North County & Escondido Physical Therapy
Tomi Theis
457 North Elm Street, Escondido, CA 92025
Telephone: (760) 489-1969 Fax: (760) 489-5226

North County & Escondido Physical Therapy

I have read and fully understand NCEPT's Notice of Patient Information Practices. I understand that NCEPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that NCEPT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in NCEPT's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Patient Signature

Date