

Fullerton Physical Therapy and Sports Care, Inc.

Patient Information

Title *	Patient Name (Last, First, Middle Initial)				
Address			City / State / Zip		
Home Phone ()		Work Phone ()		Email Address	
Social Security #		DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	Marital Status
Referring Physician					
Occupation			Employer		
Address			City / State / Zip		
Emergency Contact (Name)			Home Phone ()	Work Phone ()	

Have you had any other physical therapy or chiro services this year? <input type="checkbox"/> Y <input type="checkbox"/> N	If so, how many visits?
Have you had any home health care this year? <input type="checkbox"/> Y <input type="checkbox"/> N	

Financially Responsible Party if Not Patient

Name (First, Middle Initial, Last)			Relationship to Patient *		
Address			City / State / Zip		
Home Phone ()		Work Phone ()		Email Address	
Social Security #		DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery	Surgical Procedure			
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident		
Describe Accident					
Where you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury				
Name of employer at the time of accident		City, State, Zip Code			
Describe Injury					
Litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Attorney			Phone # ()	

FULLERTON PHYSICAL THERAPY AND SPORTS CARE, INC.

A PROFESSIONAL CORPORATION

101 LAGUNA ROAD • SUITE B • FULLERTON, CALIFORNIA 92835 • (714) 871-0460 • FAX (714) 871-5342
STEPHEN H. NICHOLAS, PT • SCOTT F. PARKER, PT • RON L. CUNNINGHAM, MPT • RYAN HARTSHORN, DPT • SARAH M. CHRISTOS, MPT

MEDICAL INFORMATION QUESTIONNAIRE

IN ORDER TO EVALUATE YOUR CONDITION FULLY, THE FOLLOWING PATIENT HISTORY IS ESSENTIAL.
PLEASE BE AS ACCURATE AS POSSIBLE.

NAME *(Please Print)* _____ DATE _____

PRESENT ILLNESS OR INJURY: _____

FOR WHAT CONDITION OR SYMPTOM ARE WE SEEING YOU? _____

WHEN DID THIS PROBLEM BEGIN? *(Date)* _____

WHAT TREATMENT HAVE YOU ALREADY RECEIVED? _____

HAVE YOU EVER HAD THIS PROBLEM IN THE PAST? _____

PAST MEDICAL HISTORY: *(PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS)*

ARE YOU PREGNANT YES NO

DO YOU HAVE A PACEMAKER YES NO

OSTEOPOROSIS YES NO

FAMILY HISTORY: HAS ANY IMMEDIATE (BLOOD) RELATIVE HAD ANY OF THE FOLLOWING: *(CIRCLE)*

ARTHRITIS

BLEEDING TENDENCY

CANCER

DIABETES

HEART DISEASE

STROKE

HEART DISEASE:

ANGINA YES NO

ANGIOPLASTY YES NO

ARRHYTHMIA YES NO

ATHEROSCLEROTIC DISEASE (CAD) YES NO

CONGESTIVE HEART FAILURE (CHF) YES NO

CORONARY ARTERY BYPASS GRAFT (CABG) YES NO

HEART ATTACK (Myocardial Infarction)-(MI) YES NO

HIGH BLOOD PRESSURE YES NO

STENTS YES NO

VALVULAR DISEASE YES NO

LUNG DISEASE:

ASTHMA YES NO

EMPHYSEMA YES NO

COPD YES NO

*** PLEASE CONTINUE ON OTHER SIDE ***

VASCULAR DISEASE:

- ACQUIRED RESPIRATORY YES NO
- BLEEDING or BLOOD DISORDERS YES NO
- CHRONIC BRONCHITIS YES NO
- DIABETES YES NO
- DISTRESS SYNDROME (ARDS) YES NO
- PERIPHERAL ARTERIAL DISEASE YES NO
- STROKE/TIA YES NO
- TAKING BLOOD PRESSURE MEDS YES NO

GENERAL MEDICAL CONDITIONS:

- ALLERGIES YES NO
- ANXIETY OR PANIC DISORDER YES NO
- ARTHRITIS (rheumatoid/osteoarthritis) YES NO
- BACK PAIN (neck pain, lower back, degenerative disc disease, spinal stenosis) YES NO
- CANCER/TUMOR YES NO
- DEPRESSION YES NO
- EPILEPSY or CONVULSIONS YES NO
- GASTROINTESTINAL DISEASE (ulcer, hernia, reflux, bowel, liver, gall bladder) YES NO
- HEADACHES YES NO
- HEARING IMPAIRMENT YES NO
- HEPATITIS/AIDS YES NO
- HERNIAS YES NO
- INCONTINENCE YES NO
- PREVIOUS ACCIDENTS YES NO
- KIDNEY, BLADDER, PROSTATE OR URINATION PROBLEMS YES NO
- NEUROLOGICAL DISEASE (such as MS or Parkinson's) YES NO
- PRIOR SURGERY(S) YES NO
- PROSTHESIS/ SURGICAL IMPLANTS YES NO
- SLEEP DYSFUNCTION YES NO
- VISUAL IMPAIRMENT (such as cataracts, glaucoma, macular degeneration) YES NO

IF CHECKED YES, PLEASE DESCRIBE _____

OTHER MEDICAL PROBLEMS NOT LISTED? _____

ALLERGIES: (CIRCLE) IODINE COMPOUNDS TAPE HEAT OIL COLD TALCUM POWDER

OTHER: _____

MEDICATIONS YOU'RE CURRENTLY USING: _____

Insurance Information

Patient Name		Patients DOB				
Primary Insurance						
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient *		
ID Card # (including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage %	Co-ins %	Co-pay \$	Pre-Determination <input type="checkbox"/> YES <input type="checkbox"/> NO	Hours per Year
		70	70	\$		
Deductible Start Amount		Deductible Remaining Amount				
\$		\$				
Benefits Verified by		Date	Signed by		Phone #	
					()	

Secondary Insurance						
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient *		
ID Card # (including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage %	Co-ins %	Co-pay \$	Pre-Determination <input type="checkbox"/> YES <input type="checkbox"/> NO	Hours per Year
		70	70	\$		
Deductible Start Amount		Deductible Remaining Amount				
\$		\$				
Benefits Verified by		Date	Signed by		Phone #	
					()	

These are your insurance benefits as quoted to us by your insurance carrier. We assume no liability for any errors made by your Insurance carrier in this quotation. We have reviewed these benefits with you and you the patient agree to pay any balance remaining after your insurance carrier has paid its portion of this bill.

Patients Initials

ASSIGNMENT OF INSURANCE BENEFITS

1. It is customary to pay for professional services when rendered. If you cannot settle your account at the time of each office visit, special arrangements must be made in advance with our office.
2. Patients who have Health Care Insurance should understand that charges for professional services are charged to the patient and not to the insurance company. Payment for charges incurred is the responsibility of the patient or the parent of patient if a minor.
3. Our office will be happy to bill your insurance carrier for you; however we cannot accept responsibility for collecting from your insurance carrier or for negotiating a settlement of a disputed claim. I hereby authorize Fullerton Physical Therapy and Sports Care, Inc. to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.
4. I have received a copy of the Notice of Privacy Practices for Fullerton Physical Therapy and Sports Care, Inc.

Patients Signature _____

Date _____

Fullerton Physical Therapy
101 Laguna Road, Suite B, Fullerton, CA 92835

Important Info for ALL Medicare Patients Regarding Home Health

Dear Medicare Patient,

Please be advised that Medicare will not cover outpatient physical therapy if you are currently receiving home health care. "Home health care" means services provided by a licensed home health agency to an insured in his/her place of residence that is prescribed by the insured's attending physician as part of a written plan of care. This can include ANY medical treatment that you receive in your home, such as nursing care, speech therapy, or chemotherapy, not just physical therapy.

If you have received any home health services, it is imperative that the home health agency formally discharges you before you begin physical therapy in our office. Even if your home health care treatment has ended, Medicare will not cover physical therapy unless they have an official home health discharge date on file. Please contact your home health agency if you have received care at home in the recent past to ensure you have been completely discharged.

If you have any questions, please stop by the billing department. We are here to provide the highest quality of patient care and are happy to help address any concerns you may have.

I have read and understand the above information regarding Medicare's policy for home health care and outpatient physical therapy.

Yes, I have had home health care. My last date of treatment at home was _____/_____/_____. I have or will contact my home health agency to make certain I was properly discharged.

No, I have not had home health care.

Patient Name: _____

Patient Signature: _____ Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

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.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____