CAMPBELL PHYSICAL THERAPY & SPORTSCARE

163 E. Hamilton Avenue
Campbell, CA 95008
(408) 866-5567

2337 Forest Ave
San Jose, CA 95128
(408) 246-5861

PATIENT INFORMATION			**EMAIL ADDRESS:**
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

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

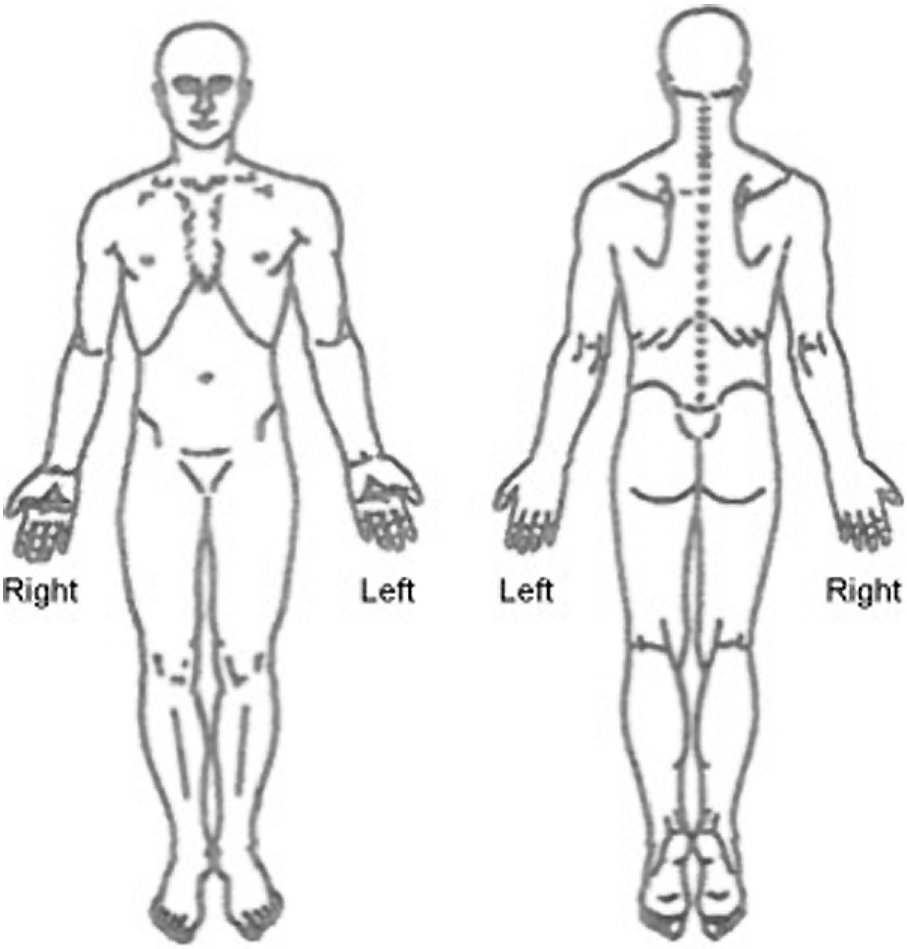
IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Campbell Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize Campbell Physical Therapy & SportsCare to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

Patient Name: _____ Date: _____

Instructions:
On the body diagram below, please indicate where your symptoms are located at the present time.



Please rate your pain on a scale from O (no pain) to 10 (worst pain lmaglneable)

present:_____lowest:_____highest:_____

over the past 30 days•

Please briefly describe when your symptoms began, cause (If known), what make's you better and worse, treatment received, and any goals you may have for physical therapy.

_____

_____

_____

_____

MEDICARE BENEFITS

Medical Necessity
Physical Therapy visits will be provided according to the medical doctor's request. When your referral limit is reached, or when your outcome goal is reached, you will be discharged at our office unless continued therapy is deemed necessary. The estimate is 10 visits, within 90 days.

Physical Therapy Cap
Medicare has implemented an annual cap on physical therapy benefits. Medicare will allow an estimated 18 visits per year, between physical therapy and speech therapy.

The purpose of this notice is to help inform you of your medical benefits. Please ask us any questions you may have in regards to your Medicare physical therapy benefits.

Please contact your insurance carrier to confirm your benefits. This is just a quote, not a guarantee of benefits or payments. It is your responsibility to confirm and make sure that your insurance pays on time. **In case of non-payment by your insurance, it is your responsibility to pay for the services.**

I have read and understand my quoted benefits. A copy of this form has been offered to me.

_____ _____

Print Name Signature

_____

Date

Campbell Physical Therapy and SportsCare
Chris Ota, PT and Associates
163 E Hamilton Avenue, Campbell, CA 95008
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cpts@campbellpt.com www.campbellpt.com

Campbell Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW OUR OFFICE WILL PROTECT YOUR HEALTH INFORMATION AND YOUR RIGHTS AT A PATIENT.

CAMPBELL PHYSICAL THERAPY'S LEGAL DUTY.
We are required by law to protect the privacy of your personal health information and will only use that information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information.

DISCLOSURE NOT REQUIRING YOUR AUTHORIZATION. In the following circumstances, we may disclose your health information without your written authorization:

To family members or close friends who are involved in your health
For certain limited research purposes
For purposes of public health and safety
To Government agencies for purposes of their audits, investigations and other oversight activities
When required by court orders, search warrants, subpoenas and as otherwise required by law.

PATIENT'S INDIVIDUAL RIGHTS. As our patient, you have the following rights:

To have access to and/or a copy of your health information
To receive an accounting of certain disclosures we have made of your health information
To request restrictions as to how your health information is used or disclosed
To request that we communicate with you in confidence
To request that we amend your health information
To receive notice of our privacy practices

CONCERNS AND COMPLAINTS. If you are concerned that we 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 Privacy Officer, Chris Ota at 408-866-5567. If you are still concerned after talking with our Privacy Officer, you may file a written complaint with the Department of Health and Human Services.

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Campbell Physical Therapy's Notice of Patient Information Practices. I understand that you 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.

_____ _____

PATIENT NAME PATIENT SIGNATURE (Guardian if patient is a minor)

_____

DATE

PATIENT NAME:_____ DATE OF BIRTH: _____

MEDICAL HISTORY

Allergies	◯ Yes ◯ No	Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cardia Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
				Vision Problems	◯ Yes ◯ No

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No Date of Fall:_____

Two or more falls in the last year? ◯ Yes ◯ No Date of Falls:_____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

24 Hour Cancellation and "No Show" Policies

The following are our policies regarding cancellations and no-shows. These policies are in effect because each time a patient misses an appointment without prior advance notice, another patient is prevented from receiving care.

- **If it is necessary to cancel or reschedule your appointment we require a 24 hour advance notice. Appointment times are in high demand and this will allow us to schedule another patient who is waiting to be treated. There will be a $20 charge for a cancellation without proper notice. This charge will not be paid by your insurance and must be paid prior to your next appointment.**

- **A "no-show" is a missed appointment without a 24 hour notice. "No-shows" also inconvenience other patients who may need access to medical care in a timely manner. Therefore, our policy allows only two LATE cancellations or two "no-shows". After that, we will not be able to schedule your visits in advance. We will still treat you, but you will need to call us on a day you are available to see if we have an open appointment to see you. If not, you will need to call on another day.**

Our goal at Campbell Physical Therapy is to provide quality medical care in a timely manner. In order to do so, we have had to implement this appointment/cancellation policy. This policy enables us to better serve you and our other patients with consistent and timely care.

I have read and understand the above policy completely and agree to all the terms.

Signed: _____ Date: _____

Print: _____

COVID-19 Screening Form

For new Patients: You are required to fill out this screening questionnaire before your first visit and then notify us before future visits if anything changes.

Name*_____Email*_____

Please carefully read and answer ALL following questions:

1. Have you had close contact with anyone with acute respiratory illness or someone who has travelled outside of the United States in the past 14 days?
   YES NO
2. Have you had COVID 19 or come in contact with a confirmed or suspected case of COVID 19 in the past 2 weeks?
   YES NO
3. Do you currently have ANY of the following symptoms?
   Fever •New onset of cough •Worsening chronic cough •Shortness of breath •Difficulty breathing •Sore throat •Difficulty swallowing •Decrease or loss of sense of taste or smell •Chills •Headaches •Unexplained fatigue/malaise/muscle aches (myalgias) •Nausea/vomiting, diarrhea, abdominal pain •Pink eye (conjunctivitis) •Runny nose/nasal congestion without other known cause
   YES NO
4. Does anyone living in your household have ANY of the above symptoms?
   YES NO
5. If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?
   YES NO

If you answer “YES” to any of above questions, we ask you to call your primary care provider for further clinical assessment.

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Declaration:

1. I have answered all the above questions honestly and truthfully and by signing below, I consent and accept the physical therapy treatments in light of the COVID-19 Pandemic.

Signature Da