

PATIENT INFORMATION			EMAIL ADDRESS:		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -		
Home Phone: () -	Alternative Phone (Cell, Pager): () -		Spouse:		
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:					
WORK INFORMATION					
Employer:			Work Phone () -	Ext.	
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date : / /	
ID. #:	Group/Policy #				
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:		
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: () -		

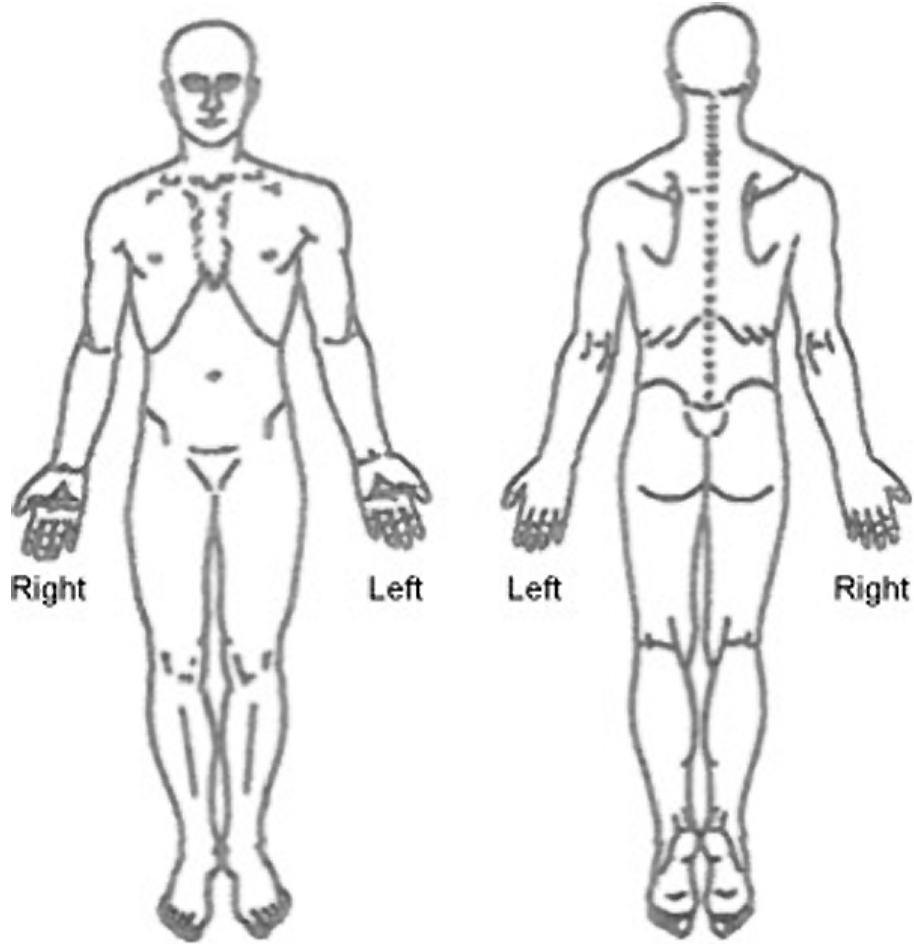
I authorize my insurance benefits be paid directly to Campbell Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize Campbell Physical Therapy & SportsCare to release any information required to process my claims.

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 0 (no pain) to 10 (worst pain imaginable)

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.

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY

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

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
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Campbell Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW OUR OFFICE WILL PROTECT YOUR HEALTH INFORMATION AND YOUR RIGHTS AS 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