PREMIER PHYSICAL THERAPY

PATIENT INTRODUCTION FORM

Date _____

Fees payable when services are rendered unless other arrangements are made

GENERAL INFORMATION

Full Name _____ Nickname _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Sex: ○ M / ○ F

Email Address _____

DOB _____ Soc. Sec.# _____ How did you find out about our group? _____

Primary Insurance Company to be billed _____ Are you a member of or have you recently

been a member of any other insurance plan? _____ Name of other insurance plan _____

Name of person responsible for account _____

Is your reason for being seen related to a work or motor vehicle accident? _____ Date of Accident _____

Emergency Contact Name _____ Home Phone _____ Cell Phone _____

EMPLOYMENT INFORMATION

Employed by _____

Employer Address _____

City _____ State _____ Zip _____ Employers Phone _____

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize **Premier PT** and whomever he/she may designate as his/her assistant to administer treatment as necessary.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance directly to me. I understand that I am personally responsible for payment.

Patient/Parent/Guardian Signature _____ Date _____

PREMIER PHYSICAL THERAPY

PATIENT INFORMATION SHEET

Name _____ Date _____

Diagnosis _____ Doctor _____

Date of onset injury _____ Occupation _____

Why did you come to physical therapy today? (Describe your symptoms): _____

_____

Other treatment you have received/are receiving for this injury/condition: _____

_____

PAST MEDICAL HISTORY

Have you ever been told you have: (circle Yes or No)

Diabetes	Yes No	Arthritis/Gout	Yes No
Hypoglycemia	Yes No	Osteoporosis	Yes No
High Blood Pressure	Yes No	Thyroid problems	Yes No
Heart Disease	Yes No	Fibromyalgia	Yes No
Angina or chest pain	Yes No	Polio	Yes No
Shortness of Breath	Yes No	Stroke	Yes No
Anemia	Yes No	Other (please describe) _____	

GENERAL HEALTH

1. Please list below any prescription, over the counter medications or nutritional supplements you are taking and for what condition: _____
2. Have you had any unexplained weight gain or loss in the last month? Yes No
3. Do you smoke or chew tobacco? Yes No How many packs/day? _____ For how long? _____
4. Do you use any recreational drugs? Yes No Which and for how long? _____
5. Do you drink alcoholic beverages? Yes No How many drinks per week? _____
6. Do you have a pacemaker, transplanted organs or metal implants? Yes No
7. Are you, or could you be pregnant? Yes No
8. How many times do you exercise each week? _____ How many minutes per session? _____

   When did you start this program? _____
9. Describe a typical exercise routine: _____

PREMIER PHYSICAL THERAPY

TO OUR PATIENTS REGARDING OFFICE POLICY

No-Show or cancellation less than 24 hours
There will be a $50 charge for a missed appointment or cancellation without proper notice.

This charge will not be covered by insurance, but will have to paid by you personally. The charge must be paid before you can be seen for your next appointment. Even if it is a last minute cancellation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients into your space. If the space is filled with another patient, the $50 charge will not apply to you.

The main reason for this policy is that a missed appointment creates a hardship on our office and the continuity of your care as well as other patients. We understand uncontrollable circumstances can occur, however there are patient waiting lists each day and most of them cannot attend an appointment in less than 24-hour notice.

We outline our policies here because we want to avoid any possible confusion.

Thank you!

I acknowledge I have read and understand this notice.

_____
Patient Name

_____ _____
Patient Signature (parent/guardian if patient a minor) Date

PREMIER PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

PREMIER PHYSICAL THERAPY'S LEGAL DUTY

PREMIER PHYSICAL THERAPY uses your personal health information for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, PREMIER PHYSICAL THERAPY 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.

PREMIER PHYSICAL THERAPY may also use or disclose your personal health information without prior public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, PREMIER PHYSICAL THERAPY'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 further disclosures at any time.

PREMIER PHYSICAL THERAPY 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. PREMIER PHYSICAL THERAPY 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 PREMIER PHYSICAL THERAPY 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 U.S. Department of Health and Human Services. For further information on PREMIER PHYSICAL THERAPY'S health information practices, or if you have a complaint, please contact:

Premier Physical Therapy
1003 River Street, Ste C
Santa Cruz, CA 95060

By signing below I acknowledge that I have read the privacy policy for PREMIER PHYSICAL THERAPY. I understand that PREMIER PHYSICAL THERAPY 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 disclose for treatment, payment and administrative operations if I notify the practice. I also understand that PREMIER PHYSICAL THERAPY will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Name _____

Patient Signature _____ Date _____