PREMIER PHYSICAL THERAPY

General Info

Please fill out all forms in **BLACK INK**

Patient Information

Patient's Legal Name: _____ **Nickname:** _____

Date of Birth: ____/____/____ **Gender:** _____ **SSN:** ____-____-____

Phone #: _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

How did you hear about us? _____

Emergency Contact

Contact Name: _____

Relationship to Patient: _____ **Phone Number:** _____

Health Insurance Information

Please Note – If you would like Premier Physical Therapy to bill your health insurance you must provide all current health insurance information at the INTIAL visit. It is the patient's responsibility to understand their insurance benefits and update Premier Physical Therapy if their insurance coverage changes at any point during treatment.

Primary Insurance Plan: _____

Secondary Insurance Plan: _____

Please provide the front desk with a copy of your insurance card(s). Copays are due at the time of service and our office will verify your PRIMARY insurance plan as a courtesy.

Have you had physical therapy visits elsewhere this year? (*please circle*): YES / NO

If YES – how many visits have you had during the current calendar year?: _____

If the patient is under 18 yrs old please fill out the following info as it pertains to the PRIMARY plan

Legal Name of Primary Insurance Subscriber: _____

Date of Birth of Primary Subscriber: ____/____/____ **Phone #:** _____

Treatment/Diagnosis Information

Patient Name: _____

Referring Physician: _____ **Clinic Name:** _____

Diagnosis/Area of Body/Injury: _____ **Onset Date:** _____

Please describe your symptoms:_____

_____

Have you or are you currently receiving any other type of treatment for this condition? If YES, what types of treatment?_____

_____

Medical History

Please 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):_____		

Other Health Related Information

1. Please list below any prescription, over the counter medications or nutritional supplements you are taking (*use back of page if necessary):*_____
   _____
2. Have you had any unexplained weight gain or loss in the last month? YES / NO
3. Do you smoke/chew tobacco? YES / NO *If YES – How often?* _____
4. Do you use recreational drugs? YES / NO *If YES – Which? How often?* _____
5. Do you drink alcoholic beverages? YES / NO *If YES – How often?* _____
6. Do you have a pacemaker, transplanted organs or metal implants? YES / NO
7. Are you, or could you be pregnant? YES / NO
8. Do you currently have an exercise routine? YES / NO *If YES – How many sessions per week?* _____
9. **In the space below** - Please describe a typical exercise routine (*cardio, strength training, sports, etc..)*:
   _____

Cancellation and No-Show Policy

In an ongoing effort to offer high quality healthcare at an affordable rate, we request twenty-four-hour notice for any changes made to a scheduled appointment. Missed and late-cancelled appointments create a hardship on our office, and affect the continuity of care we provide our patients. We understand uncontrollable circumstances can occur, and will take each situation into consideration; however, **all appointments that are either missed or cancelled with less than twenty-four hours' advance notice by a phone call or email to our office are subject to a $50.00 cancellation fee.**

This is an office policy and is non-negotiable

Please note that this charge cannot be billed to your insurance and is your responsibility

_____	_____	_____
Patient/Guardian Name	***Patient/Guardian Signature***	***Date***

Consent For Treatment

I, the undersigned, a patient in this office hereby authorize Premier Physical Therapy and whomever they may designate as their 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/Guardian Signature:_____

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 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 disclosed 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/Guardian Name	***Patient/Guardian Signature***	***Date***