MONTEREY PENINSULA
PHYSICAL THERAPY
ORTHOPEDIC, SPINAL AND SPORTS MEDICINE REHABILITATION

337 EL DORADO STREET, SUITE B-5
MONTEREY, CA 93940
(831) 646-1100

PATIENT INFORMATION SHEET

PATIENT'S NAME:_____ **DATE OF BIRTH:**____/____/_____
CURRENT AGE:_____ **SEX:** **MARTIAL STATUS:**
STREET ADDRESS:_____
CITY:_____ **STATE:**_____ **ZIP:**_____
HOME PHONE: (_____) _____ **CELL NUMBER:** (_____) _____
EMAIL ADDRESS: _____

NAME OF INSURED / RESPONSIBLE PARTY: _____
RELATION TO PATIENT: _____
STREET ADDRESS OF INSURED: _____
CITY:_____ **STATE:**_____ **ZIP:**_____

INSURANCE CARD INFORMATION: **(AS IT APPEARS ON YOUR CARD)**
SUBSCRIBER NAME: _____
INSURANCE COMPANY:_____
ID#: _____ **GROUP#:** _____

PATIENT'S EMPLOYER: _____
BUSINESS STREET ADDRESS:_____
CITY:_____ **STATE:**_____ **ZIP:**_____
PHONE: (_____) _____ **OCCUPATION:**_____

WORKERS COMPENSATION: (COMPLETE ONLY IF WORK RELATED INJURY)
NAME OF EMPLOYER (WHERE INJURY OCCURRED): _____
EMPLOYERS ADDRESS: _____
CITY:_____ **STATE:**_____ **ZIP:**_____
DATE OF INJURY: _____/_____/_____ **CLAIM #:** _____
ADJUSTOR'S NAME: _____ **PHONE:** (_____) _____ **EXT:** _____
NAME OF ATTORNEY: _____ **PHONE:** (_____) _____

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU)

NAME: _____ **PHONE:** (_____) _____

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PATIENT MEDICAL HISTORY FORM

Name: _____ TODAY DATE: _____
Treating Physician:_____ Date of 1st Doctors Visit For this Injury:_____
Family Physician: _____
Last Day Worked Due to this Injury: _____ Date Returned to Work After Injury: _____
Is an attorney involved in this case? **YES** ○ **NO** ○ Were you referred to PT by:_____
If yes, name of attorney: _____
Have you had Surgery for this Injury? **YES** ○ **NO** ○ Number of Surgeries: _____
Type of Surgery: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications: (Please List Below)
Anti-Inflammatories _____
Muscle Relaxers _____
Pain Medication _____
Other _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Physical Therapy	○	○	General Practitioner	○	○
Orthopedist	○	○	Neurologist	○	○
Speech Therapy	○	○	Occupational Therapy	○	○
Podiatrist	○	○	Massage Therapy	○	○
X-Rays	○	○	MRI	○	○
CT Scan	○	○	EMG/NCV	○	○
Emergency Room Care	○	○	Chiropractor	○	○

Do you now or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	○	○	High Blood Pressure	○	○	Anemia	○	○
Shortness of Breath/Chest Pain	○	○	Heart Attack or Surgery	○	○	Diabetes	○	○
Coronary Heart Disease or Angina	○	○	Thyroid Trouble/Goiter	○	○	Gout	○	○
Cancer/chemotherapy/Radiation	○	○	Dizziness or Fainting	○	○	Weakness	○	○
Emotional/Psychological Problems	○	○	Infectious Diseases	○	○	Hernia	○	○
Bowel or Bladder Problems	○	○	Numbness or Tingling	○	○	Allergies	○	○
Severe or Frequent Headaches	○	○	Elbow/Hand Injury	○	○	Osteoporosis	○	○
Vision or Hearing Difficulties	○	○	Neck Injury/Surgery	○	○	Stroke/TIA	○	○
Sleeping Problems/Difficulties	○	○	Back Injury/Surgery	○	○	Blood Clot/Emboli	○	○
Leg/Ankle/Foot Injury/Surgery	○	○	Knee Injury/Surgery	○	○	Epilepsy/Seizures	○	○
Do you have a Pacemaker?	○	○	Arthritis/Swollen Joints	○	○	Varicose Veins	○	○
Any Pins or Metal Implants?	○	○	Are You Pregnant?	○	○	Joint Replacement	○	○
Weight Loss/Energy Loss	○	○	Do You Smoke?	○	○			

List any other information that would assist us in your care? _____
_____

Are you aware of what your diagnosis is (what you're being treated for)?_____
Based upon your awareness, what are your expectations/goals while in this program? _____
_____

Patient/Guardian Signature: _____ Date: ____/____/____

Therapist Signature: _____

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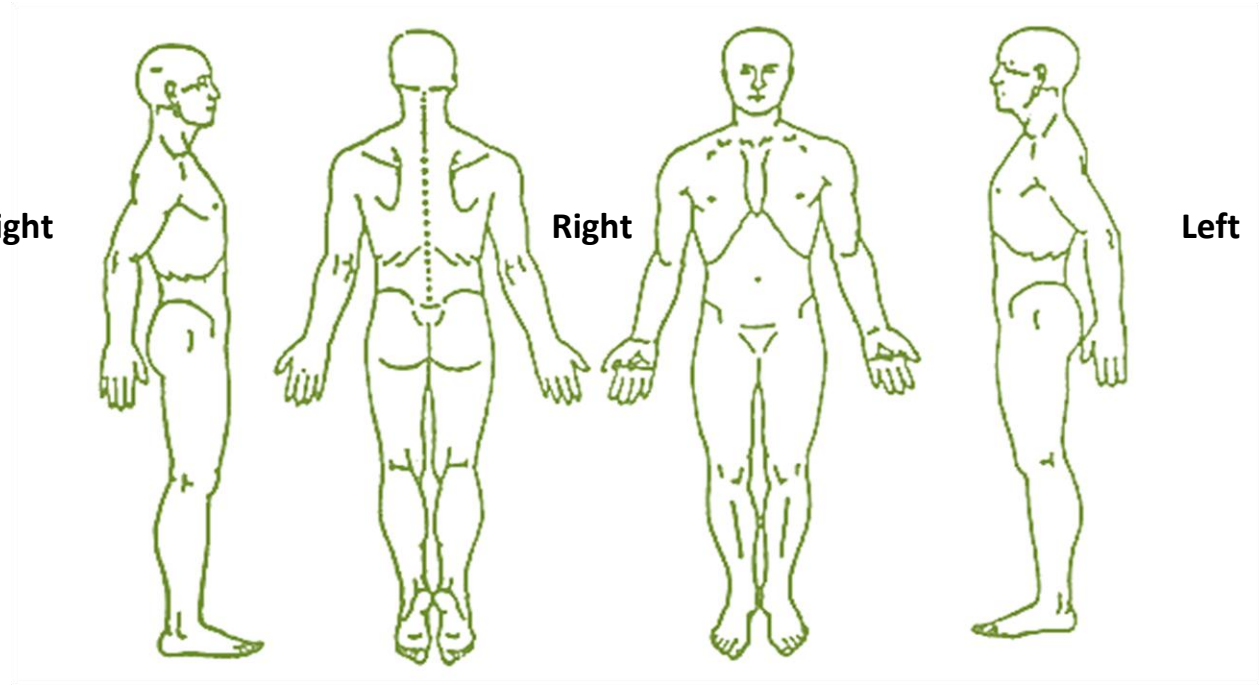
MEDICAL HISTORY

1) PLEASE MARK ON THE DRAWING BELOW THE AREAS WHERE YOU FEEL DISCOMFORT



No Pain **Severe Pain**

2) INDICATE PAIN RANGE : 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

3) TYPE OF PAIN: SHARP ☐ DULL / ACHY ☐ TINGLING ☐ NUMBNESS ☐ BURNING ☐

4) WOMEN'S HEALTH: FEMALES COMPLETE THE FOLLOWING SECTION:

Are you pregnant? ☐ No Yes ☐ NUMBER OF WEEKS PREGNANT: _____WEEKS

DUE DATE: _____/_____/_____ C-SECTION DATE: _____/_____/_____

CURRENT WEIGHT:_____ LBS PRE PREGNANCY WEIGHT: _____ LBS

Number of pregnancies:_____ Number of vaginal deliveries: _____

Number of cesarean deliveries: _____ Height:_____ft _____inches

MONTEREY PENINSULA PHYSICAL THERAPY

337 EL DORADO STREET, SUITE B-5, MONTEREY, CA 93940
(831)646-1100

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION FORM

1. The **PATIENT IS FULLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES** regardless of insurance or lawsuit determination. All charges are expected to be paid in full. We accept payments by cash or check. If payment arrangements are made we must have a signed Payment Contract from you. Any overpayments will be promptly refunded to the patient.

2. **HEALTH INSURANCE** Patients wishing us to bill their primary insurance carrier must provide us with current insurance information You are responsible for any deductible, cost share and non-covered services as per your insurance policy. Deductibles and co pays are expected at the time services are rendered. You will be billed for any cost shares or non-covered services.

3. **WE DO NOT BILL SECONDARY CARRIERS.** The patient is responsible for billing any secondary or third insurances and issuing payment to our office for the allowed amounts as per your policy guidelines. Our office may assist you as a courtesy to you.

4. **RETURNED CHECKS** will be subject to a $25.00 service charge.

5. **FINANCE CHARGES** will be added to unpaid balances over 30 days at the rate of 10% per year (.83% per month). This is billed directly to the patient.

6. **PLEASE BE PROMPT FOR YOUR APPOINTMENT TIME.** We realize that everyone's time is important and we make every effort to see you promptly at your scheduled appointment time. **YOU MAY BE CHARGED THE FULL OFFICE VISIT** for any missed treatments or canceled appointments not given **24 hours notice**.

7. **PLEASE KEEP US INFORMED.** Let us know of your appointments with your physician so that we may prepare a report for him regarding your progress/status. Notify us of any changes in your personal information, (i.e. address, insurance, name changes, etc)

I FULLY UNDERSTAND THE ABOVE FINANCIAL AGREEMENT AND WILL BE COMPLETELY RESPONSIBLE FOR PAYMENTS FOR SERVICES RENDERED. I ALSO AUTHORIZE TREATMENT FOR THE PATIENT STATED BELOW.

(GUARDIAN SIGNATURE REQUIRED IF MINOR UNDER THE AGE OF 18)

DATE:_____ **PRINTED NAME:** _____

SIGNATURE:_____ **RELATION:**_____

ASSIGNMENT OF BENEFITS AND RELEASE: I hereby authorize my insurance benefits be paid directly to **Monterey Peninsula Physical Therapy** and agree that I am financially responsible for non-covered services. I also authorize the release of any information requested to process this claim.

DATE: _____ **PRINTED NAME:** _____

SIGNATURE: _____

MONTEREY PENINSULA PHYSICAL THERAPY

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPPA) I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payer.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the rights to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the right to change it ***Notice of Privacy Practices*** from time to time and that I may contact his organization at any time at the address below to obtain a current copy of the ***Notice of Privacy Practices. Attention: Tony Lagana, 337 El Dorado, Suite B-5, Monterey, California 93940***
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payment or other health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

Patient name: (PRINT) _____

Signature: _____

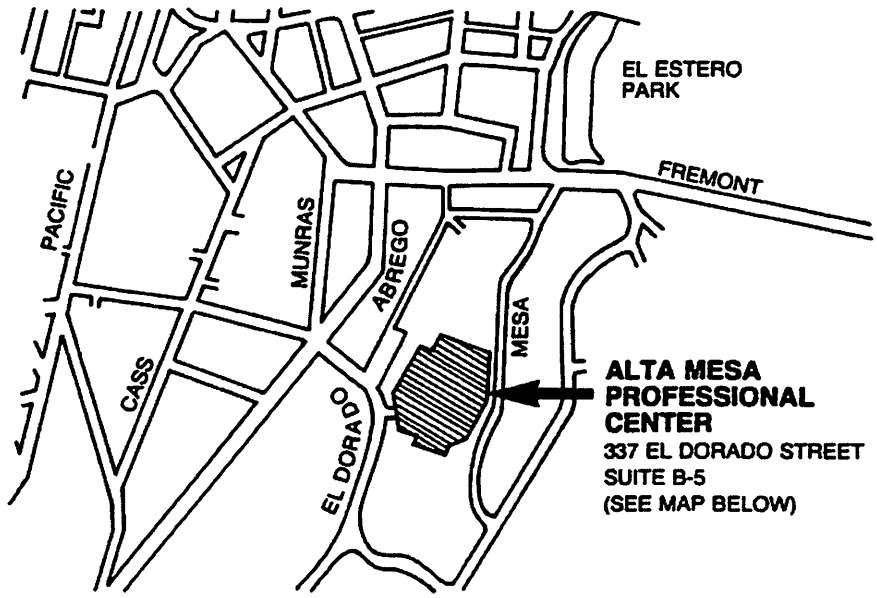
RELATIONSHIP TO PATIENT: _____

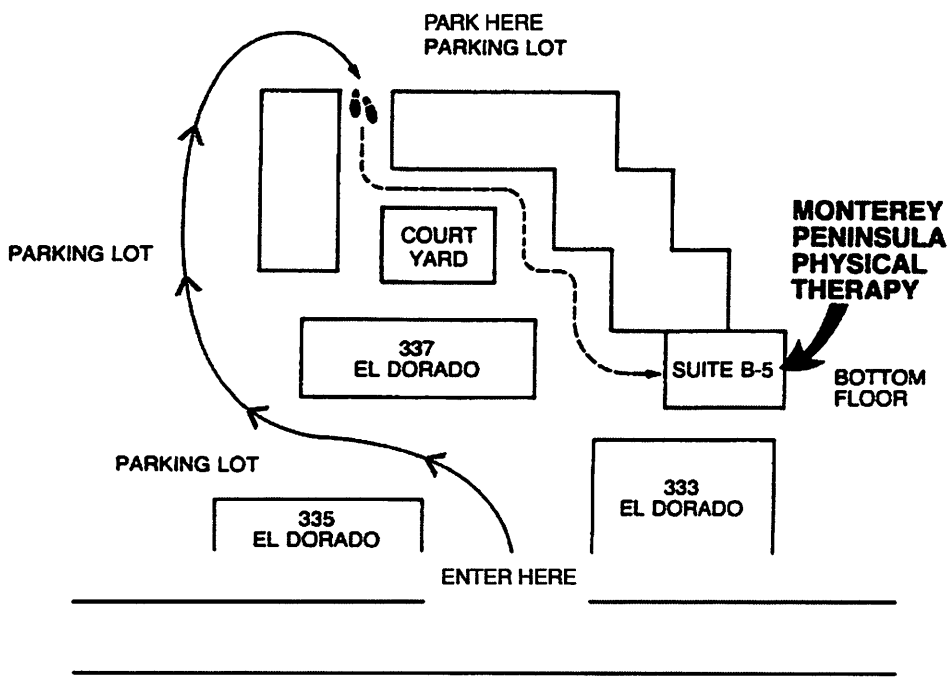
DATE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature is acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	*Initials:*	*Reason:*


EL ESTERO PARK
FREMONT
PACIFIC
MUNRAS
ABREGO
MESA
CASS
EL DORADO
ALTA MESA PROFESSIONAL CENTER
337 EL DORADO STREET
SUITE B-5
(SEE MAP BELOW)


PARK HERE
PARKING LOT
PARKING LOT
COURT YARD
MONTEREY PENINSULA PHYSICAL THERAPY
337 EL DORADO
SUITE B-5
BOTTOM FLOOR
PARKING LOT
335 EL DORADO
333 EL DORADO
ENTER HERE