

Physicians Choice Physical Therapy Patient History

Name: _____ Sex: M ___ F ___ Birthday: _____ Date: _____

<u>Have you ever had or currently have:</u>	<u>If yes, please explain:</u>	<u>Family History?</u>
High Blood Pressure:	Yes___ No___ _____	Yes___ No___
Heart Problems:	Yes___ No___ _____	Yes___ No___
Seizures:	Yes___ No___ _____	Yes___ No___
Dizzy Spells:	Yes___ No___ _____	Yes___ No___
Diabetes:	Yes___ No___ _____	Yes___ No___
Cancer:	Yes___ No___ _____	Yes___ No___
Arthritis	Yes___ No___ _____	Yes___ No___
Osteoporosis:	Yes___ No___ _____	Yes___ No___
Immune Deficiency:	Yes___ No___ _____	Yes___ No___
Depression:	Yes___ No___ _____	Yes___ No___
Incontinence:	Yes___ No___ _____	Yes___ No___
Abnormal Vision:	Yes___ No___ _____	Yes___ No___
Abnormal Hearing:	Yes___ No___ _____	Yes___ No___
Angina or Chest Pain:	Yes___ No___ _____	Yes___ No___
Shortness of breath:	Yes___ No___ _____	Yes___ No___
Urinary Tract Infect:	Yes___ No___ _____	Yes___ No___
Metal Implant in body:	Yes___ No___ _____	Yes___ No___
Allergies:	Yes___ No___ _____	Yes___ No___
Weight gain /loss:	Yes___ No___ _____	Yes___ No___
Other:	Yes___ No___ _____	Yes___ No___

Please list surgeries you have had; please give procedures and dates, if possible: _____

Please list any accidents or injuries you have had: _____

Please list recent diagnostic studies (i.e. CAT Scan, MRI, X-rays): _____

Other problems that have been diagnosed by a physician? Yes___ No___

Please list all medications you are now taking: _____

(For women only) Are you pregnant now? Yes___ No___ Date of last menstrual cycle: _____

Have you ever taken steroids or anti-coagulants for an extended period of time? Yes___ No___

Have you ever had physical therapy treatments before? Yes___ No___

If yes, please indicate where, and for what problem: _____

What are your goals in Physical Therapy? _____

Physicians Choice Physical Therapy

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand Physicians Choice Physical Therapy's Notice of Information Practices. I understand that Physicians Choice 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 Physicians Choice Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physicians Choice Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

I also authorize Physicians Choice Physical Therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date

PHYSICIANS CHOICE PHYSICAL THERAPY

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Physicians Choice Physical Therapy to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Physicians Choice Physical Therapy to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Physicians Choice Physical Therapy, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

Physicians Choice Physical Therapy
12113 Santa Monica Blvd #203
West Los Angeles, CA 90025

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of \$50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Patient or Guardian Signature

Date