



Patient Intake Information

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 Spectrum Orthopedic Sport Therapy. I understand that I am financially responsible for any balance. I also authorize Spectrum Orthopedic Sport Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			OTHER CONDITIONS		
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			OTHER CONDITIONS		
	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? : _____

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative _____

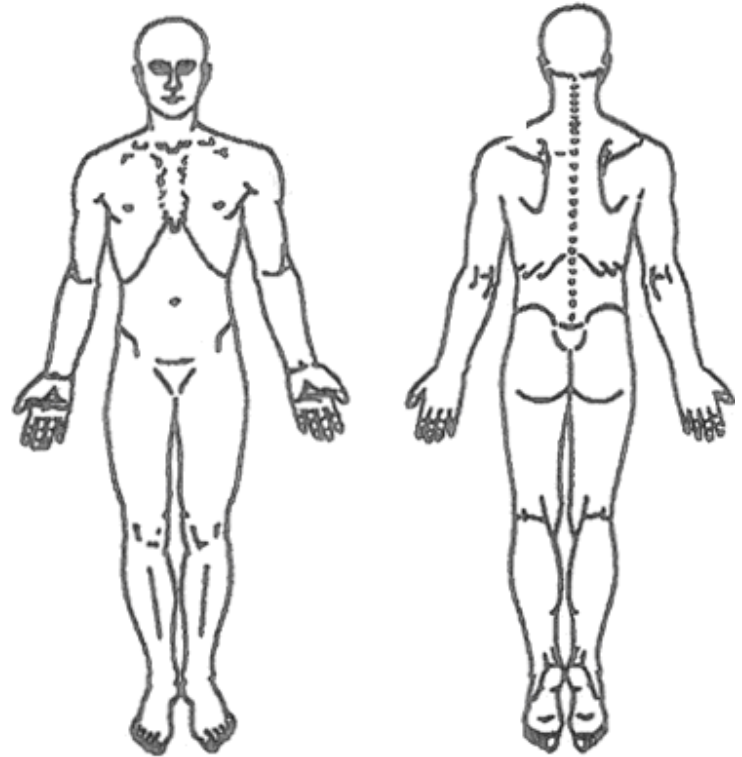
Date _____

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- | | | |
|---|------------------------------|--------------------------------|
| Ache
MMM
M | Burning

--- | Numbness
OOOO
OOO |
| Pins and Needles
□□□□□□□□
□□□□□□□□ | Stabbing
///// | Other
xxxx
xxx |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your **CURRENT** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your **AVERAGE** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your **WORST** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Additional Comments _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SPECTRUM ORTHOPEDIC SPORT THERAPY LEGAL DUTY

Spectrum Orthopedic Sport Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Spectrum Orthopedic Sport Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we 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.

Spectrum Orthopedic Sport Therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. 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. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Spectrum Orthopedic Sport Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be available at the office front desk. 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. Spectrum Orthopedic Sport 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 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 at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Spectrum Orthopedic Sport Therapy
Attn: Privacy Officer – Ken Burns
1200 Industrial Road, Suite 1
San Carlos, CA 94070

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Spectrum Orthopedic Sport Therapy's Notice of Information Practices. I understand that Spectrum Orthopedic Sport 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 Spectrum Orthopedic Sport 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 Spectrum Orthopedic Sport 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 Spectrum Orthopedic Sport 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

OFFICE PAYMENT POLICY – SPECTRUM ORTHOPEDIC SPORT THERAPY

It is the policy of Spectrum Orthopedic Sport Therapy to collect any moneys due for all applicable deductible, co-insurance, co-pay's and/or self payments on the date services are rendered as indicated as due and payable by the patient's insurance company (if applicable). A receipt will be given for the collection of moneys received in the facility. It is also the policy of Spectrum Orthopedic Sport Therapy to assure that all fiscal obligations are satisfactory for the patient and that every effort is made to assure the patient receives the scheduled care without regard to fiscal obligations. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 60+ minutes long. If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with select insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does **not** necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do **not** assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manger before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a copay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and copays are due at the time of service. We will bill you for coinsurance or other payment due after we have been paid by your insurance or notified of their denial for payment.

_____ 2. MEDICARE: Spectrum Orthopedic Sport Therapy is a Medicare provider. Medicare has an annual deductible of \$100.00 for PT and Speech. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

_____ 3. NO INSURANCE: If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____ 4. OTHER: Please list the other type of payment: _____

_____ 5. WORKER'S COMPENSATION CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

_____ 6. THIRD PARTY PAYERS: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. You are responsible for payment of all service provided. Please be sure to contact this office when your case is settled to ensure your account has been paid. ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS: Please sign a release of information authorizing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____