Name: ______________________ Date: ___________

**Medical History – Use the back of this page if you need more space Medicare patients Only: Please state your Weight: ____________ Height: ___________**

1) Briefly describe the history of your present accident, injury or illness and the date of onset:
_______________________________________________________________________________________

2) Any past medical history that may affect your ability to perform physical therapy now (joint replacements, stroke, surgeries, etc.?) ___________________________________________________

3)What is your occupation? ______________________________________________________________

4)Please list surgeries you have had. Please give us procedures and dates if possible:
_____________________________________________________________________________________

5)Have you recently had an X-ray, MRI, CT scan or EMG? _____________________________________

6)Do you have any metal anywhere in your body other than teeth (pins/plates post fracture, or **pacemaker** etc.?) __________________________________________________________________

7)(for women only) Are you now pregnant? ___________ Date of last menstrual cycle: ___/____/____

8)Do you have any abnormal trouble with vision? ____________________ Hearing? _____________

9)List any allergies you have: ____________________________________________________________

10)List all prescriptions/over the counter medications, herbals, vitamins, minerals and dietary nutritional supplements. Medications you are now taking, dosage (how much), frequency (how often) and route of administration (pill, injection, lotion, patches) ________________________________________________
_______________________________________________________________________________________

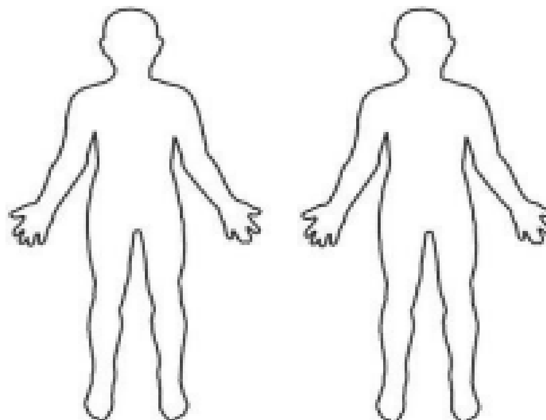
11)Have you ever had physical therapy before? If so, where and when? __________________________

12)Did you have home health care or hospital therapy prior to coming here? _______________________

13)Have you ever had: (If "Yes", please explain)

O Alzheimer's
O Cardiovascular Disease
O Immunosuppression
O Lupus
O Muscular Dystrophy
O Obesity
O Osteoarthritis
O Fracture or Suspected Fracture
O High Blood Pressure
O Recent falls in the past year
O **History of Cancer** – Yes or No
O Huntington's
O Cerebral Vascular Accident
O Current Infection
O Diabetes
O Fibromyalgia
O Parkinson's
O Rheumatoid Arthritis
O Traumatic Brain Injury
O Other

14)Indicate on the body chart where your present
Pain is located. Rate your pain:
0= None 5=Moderate 10=Extreme
At Worst: ________
Current: _________
At Best: _________
Circle the type of pain:
Sharp, Burning, Dull/Achy, Throbbing
Shooting, Numbness/Tingling, Constant
Intermittent, Worse AM, Worse PM



**FRONT** **BACK**

Name: ______________________ Date: ________

## Section I Patient Information

**Please fill out this form as complete as possible. This information will remain confidential unless authorized for release by patient.**

LastName ______________________ First Name________________________ Date ________________
Address ________________________________City ________________ State _____ Zip _____________
Home P# (___) _____________ Cell P# (___) _______________ Work P# (___) _____________________
The best time to contact me is: ___A.M. ___ P.M on my ____ Home P# ____Cell P# _____ Work P#_____
Email Address: ______________________________________Appointment Reminder ____Text ____Call
Date of Birth ____/____/____ Age ____ Social Security Number ______________________ Sex _______
Employer: ___________________________________ Position: _________________________________
Address:____________________________________City ________________ State _____ Zip ________
EmergencyContact: ____________________Relationship: ________________ P# (___) ____________
Is there an attorney involved with your case? ___ If yes, Attorney's name: _________Phone#: ________

_____________________________________________________________________________________

## Section II Insurance Information

********PLEASE FILL OUT THE INFORMATION THAT APPLIES TO YOU********

Private Insurance Information

InsuranceCompany_____________________________________________________________________
Address __________________________________ City _______________ State _______ Zip _________
ID# ______________________________ Group # ____________Subscribers SSN___________________
Subscribers Relationship to Patient ______________________________

**---DO YOU HAVE A SECONDARY INSURANCE?** ___ Yes ___ No IF YES, COMPLETE THE FOLLOWING ---

InsuranceCompany_____________________________________________________________________
Address __________________________________ City _______________ State _______ Zip _________
ID# ______________________________ Group # ____________Subscribers SSN___________________
Subscribers Relationship to Patient ______________________________

Workman's Compensation Information

Insurance Company _________________________________________ Date of Injury _______________
Claim # ______________________ Adjuster ________________ Adjusters P#______________________

Auto Accident Information

Insurance Company _________________________________________ Date of Accident _____________
Claim# ______________________ Adjuster ________________ Adjusters P# ______________________
Attorney_____________________________ Attorney's P# _____________ F# _____________________

Name: ______________________ Date: ________

**CONSENT FOR CARE & TREATMENT**

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Solano Sports Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

**APPOINTMENT POLICY:**

Your referring doctor has prescribed therapy for you and physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, not attending scheduled sessions may be jeopardizing your progress and also may adversely affect your disability status. Please be on time for your appointment so that you may be given the full benefit of your scheduled treatment. We require 24-hour advance notice of appointment cancellation or rescheduling.

**RESPONSIBILITY**

It is your responsibility to contact your insurance company to verify your coverage for outpatient physical therapy. You need to verify your percentage of payment per visit, any copayments, deductibles, and limits of visits per calendar year. We at Solano Sports Physical Therapy will be glad to bill your insurance as a courtesy to you. However, it is your responsibility for any portion not paid by your insurance. If you need any assistance in this matter, please feel free to contact our office staff.

**ASSIGNMENT OF INSURANCE OR HEALTH BENEFITS TO CLINIC:**

I, the undersigned, assigns and hereby authorizes, direct payment to the clinic of all insurance and plan benefits otherwise payable to or on behalf of the patient for these outpatient services at a rate not to exceed the clinics regular charges. It is understood that I, the undersigned, am financially responsible for charges not covered by this assignment.

**FINANCIAL POLICY:**

We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. We assume no liability for any errors made by your insurance carrier in this quotation. You agree to pay your portion of this bill.

I, the undersigned, certify that the above information has been read and I execute the above and accept its terms.

___________________________________________ _________________________

Signature of Patient, Parent or Guardian Date

Name: ______________________ Date: ________

## Waiver and Release of Liability

In the consideration of the undersigned being permitted to use the facilities and equipment of Solano Sports Physical Therapy, Inc., the undersigned, individually and on behalf of the undersigned's heirs, representatives and next of kin agrees to (I) release , waive and discharge, and to indemnify and hold harmless, Solano Sports Physical Therapy, Inc. and its employees and affiliates, from all loss, expense and liability for injury, death or damage to the person or property of the undersigned, whether caused by negligence of Solano Sports Physical Therapy, Inc., its employees or affiliates, or otherwise, while using Solano Sports Physical Therapy, Inc., facilities or equipment; and (II) assume full responsibility for risk of injury, death or damage to the person or property of the undersigned, while using Solano Sports Physical Therapy, Inc., facilities or equipment.

The undersigned acknowledges that no oral or written statements or arrangements contrary to this document have been made to the undersigned and that this document supersedes any and all prior statements and agreements with Solano Sports Physical Therapy, Inc. This document may only be changed in writing executed by Solano Sports Physical Therapy, Inc.

The agreements in this document shall be continuing and shall not terminate without the prior written consent of Solano Sports Physical Therapy, Inc.

The undersigned understands the possible risks and dangers involved in using physical rehabilitation facilities and equipment. The undersigned has read, understands and voluntarily signs this document.

___________________________________________

Print Name

___________________________________________ __________________________

Signature of Patient, Parent or Guardian Date

Name: ______________________ Date: ________

# Health Insurance Portability and Accountability Act (HIPAA)

# Consent Form

I hereby acknowledge that a current notice of Solano Sports physical Therapy, Inc's Notice of Privacy Practices is posted in the reception area. I further acknowledge that a copy of the Notice of Privacy Practices is available to me if I request it.

I further acknowledge that the list of people below are not directly involved with my medical care but are authorized to receive medical information pertaining to me. These people may include, but are not limited to, spouses, employers, friends, parents and/or emergency contacts. If patient is under the care of a parent or legal guardian, the parent or legal guardian will provide this information. I AM UNDER NO OBLIGATION TO FILL THIS SECTION OUT. SOLANO SPORTS PHYSICAL THERAPY, INC. IS HIPPA COMPLIANT AND WILL NOT RELEASE INFORMATION TO UNAUTHORIZED PERSONNEL WITHOUT MY WRITTEN CONSENT.

| Name | Relationship | Patient Initials |
|---|---|---|
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |
| __________________________ | ____________________________ | ______________ |

________________________________

Print Name

________________________________ ___________________

Signature of Patient, Parent or Guardian Date

## APPOINTMENT AND PAYMENT AGREEMENT

Patients are seen by appointment only. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep an appointment, please notify our office immediately. This courtesy on your part makes it possible to give an appointment to another person who needs Treatment.

We reserve the right to charge $50 for appointments broken or canceled without a 24 hour notice. Your insurance company is not responsible for this charge. Repeated tardiness or not showing for scheduled appointments 2 or more times will result in your future appointments being deleted. (If you are a workers comp patient, your case manager and physician will be notified)

We appreciate patients arriving early for appointments; however, arriving early does not ensure you will be seen before your scheduled appointment time.

Thank you for your cooperation!

___________________________________ ____________________

Signature of Patient, Parent or Guardian Date