

PATIENT INFORMATION

ACCT# _____

SOCIAL SECURITY # _____

DRIVER'S LICENSE# _____

 MARRIED SINGLE WIDOW DIVORCED

 NAME _____ BIRTHDATE ____ - ____ - ____ AGE ____ SEX ____
Last First MI

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE HOME() _____ MOBILE() _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE () _____ EMAIL: _____

 EMERGENCY CONTACT _____ PHONE() _____
Last First MI
REFERRING PHYSICIAN

LAST SEEN MD ____ - ____ - ____ UPIN _____ NPI _____

REFERRING PHYSICIAN _____ PHONE() _____

DIAGNOSIS _____ ICD 9 CODE _____ DOI ____ - ____ - ____

Do you currently or have you in the past 6 months had home healthcare services? Yes NoHave you been hospitalized in the past 60 days? Yes No

If yes to either question, who is your home health provider? _____

What is the discharge date for your hospitalization/home healthcare services? _____

MEDICAL INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S)
Please provide Name of Insured and Birthdate for all plans.

 SELF PRIVATE AUTO LIEN MEDICARE WORK COMP OTHER _____

INSURANCE _____ GROUP# _____ ID# _____

NAME OF INSURED _____ BIRTHDATE ____ / ____ / ____ SEX _____

WORKERS' COMPENSATION INFORMATION

DOI ____ - ____ - ____

ADJUSTOR _____ CLAIM# _____ PHONE() _____

AUTHORIZED BY _____ DATE _____ DURATION _____

ATTORNEY _____ ADDRESS _____ PHONE() _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY
 NAME _____ SOCIAL SECURITY # _____
Last First MI

RELATIONSHIP TO THE PATIENT _____ BIRTHDATE ____ / ____ / ____ SEX _____

ADDRESS _____ HOME PHONE () _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE () _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider of medical services and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to CENTRAL COAST PHYSICAL THERAPY and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize CCPT to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____



Central Coast Physical Therapy

PAST MEDICAL HISTORY:

Please circle any condition that you currently have or have had in the past:

High blood pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Are you allergic to latex? YES NO
 Do you Smoke? YES NO
 Are you Pregnant? YES NO

During the past month have you often been bothered by feeling down, depressed, or hopeless? YES NO
 During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

Are you currently taking any medications? YES NO

If yes, please list ALL medications you are currently taking:

Please list past surgeries and dates:

Please list any medical conditions you have that have not been documented above:

What are your physical therapy and/or fitness goals?:

Patient signature: _____ Date: _____



Central Coast Physical Therapy

Medical Screening Form

Name _____ Date: _____

CURRENT CONDITION:

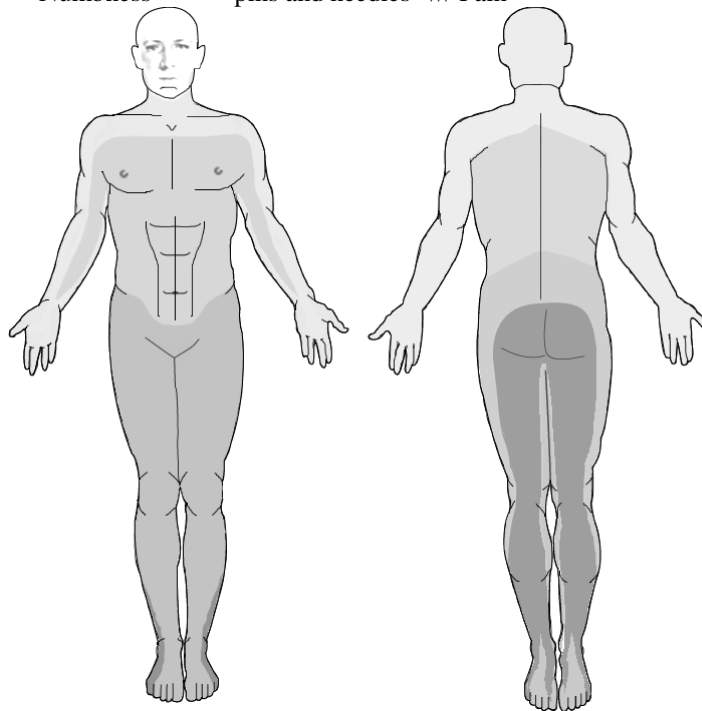
When did these symptoms start? _____

How did the injury occur?: (gradually, suddenly, injury): _____

My symptoms are currently: getting better / about the same / getting worse
Please list any previous treatment for the condition we are seeing you for today: _____

Have you ever had this problem before? YES NO
If so how was the problem treated? _____

Have you had any imaging studies done for this problem (x-rays, MRI, etc.) YES NO
Please use the following symbols: ^^ Numbness *** pins and needles /// Pain



Rate your pain (1=mild, 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10
Right now: 1 2 3 4 5 6 7 8 9 10

Currently I am experiencing the following (circle all that apply): dizziness
Unexplained weight loss difficulty swallowing changes in bowel or bladder function
Increased pain at night headaches depression
Fever/chills/sweats nausea/vomiting shortness of breath
Changes in appetite numbness or tingling poor balance/falls



Central Coast Physical Therapy

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OFFICE POLICY

Consent To Treatment: I the undersigned agree to give my consent to Central Coast Physical Therapy to furnish physical therapy care and treatment services. These services include but are not limited to therapeutic test/s, treatments or procedures, manipulation, stretching, or exercise as directed under the general instructions of the Physical Therapist, Physical Therapist Assistant, or Physical Therapy Aide. I authorize my Physical Therapist(s) to take photographs relating to my physical condition as are deemed necessary.

Consent for treatment of a Minor: As parent and/or legal guardian, I authorize Central Coast Physical Therapy to treat _____ (minors name) while I am not present.

Assignment of Insurance Benefits: I hereby authorize Central Coast Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Workers Compensation Claims: If you claim workers compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Cancellation and No-Show Policy: Central Coast Physical Therapy requires a 24 hour notice in the event of a cancellation. The charge for cancellation or no-show without proper notice is \$25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Co-Payments: Co-payments may be paid at the time of service. If your co-payment is not paid at the time of service you will be billed for your contracted co-payment.

Non-Sufficient Funds: Checks returned for non-sufficient funds may be subject to a \$25 processing fee.

Patient/Guardian/Responsible Party Signature

Date

Print Name

Financial Policy: We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Central Coast Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. If formal collections procedures become necessary you will be responsible for additional costs incurred. Furthermore, I understand that I cannot change my chosen payment option after services have been rendered .

I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment. _____(please initial).

I choose to have Central Coast Physical Therapy bill my insurance company. It is my responsibility to understand my physical therapy benefits and coverage. _____(please initial).

The above financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party Signature

Date