



NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: _____ Email Address: _____

Name: (First) _____ (Last) _____ (M.I.) _____

Home Address: _____

Mailing Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: M / F

Drivers Lic #: _____ Emergency Contact: _____ Telephone: _____

Referring Physician: _____
Referring Dr. Address: _____ Phone Number _____

Status Married / Single / Divorced / Separated / Widowed	Student	No / Full-Time / Part-Time
Employment Full-Time / Part-Time / None / Retired	Employer _____	

Do you currently or have you in the past 6 months had Home Healthcare Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been hospitalized in the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to either question, who is your Home Healthcare Provider: _____
Have you had physical and/or speech therapy treatment this year? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, where? _____
How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Phonebook <input type="checkbox"/> Brochure <input type="checkbox"/> Employer <input type="checkbox"/> Other _____

Injury Type: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Other: _____	Date of Injury: _____
If Work Comp Claim: Employer at time of Injury: _____	Phone: _____
Attorney Involved? Yes / No Attorney Name: _____	Telephone #: _____

Primary Insurance: _____	Subscriber Name: _____
Relationship to Patient: _____	Subscriber: _____
	<small>ID# Date of Birth Group/Policy #</small>
Secondary Insurance: _____	Subscriber Name: _____
Relationship to Patient: _____	Subscriber: _____
	<small>ID# Date of Birth Group/Policy #</small>

Patient Signature: _____ Date: _____

(OFFICE USE ONLY BELOW THIS LINE)

Area(s) Being Treated: _____

Diagnosis Code: _____ Description: _____

Program Code: _____ Therapist: _____

Financial Class: CASH B Cross B Shield HNet UHC MC W/C Indust CCPN Auth #: _____

PQRI Questions Discussed? Y N (If yes, Date: _____) Charge Ticket Marked? Y N (If yes, Date: _____)

Office: AG Atas Bksf Galt Lodi MB Paso SLO SM SMMain Stock Temp HAND: SLO SM SMMain Temp



PRIVACY & SECURITY

DELTA PHYSICAL THERAPY
COMPLIANCE PROGRAM
PRIVACY AND SECURITY COMPLIANCE PLAN
PRIVACY & SECURITY NOTICE

Delta Physical Therapy, in compliance with certain laws, has taken reasonable and comprehensive steps towards the protection of the privacy and security of your personal health information. Such information may include oral, written, telephone, facsimile and/or other electronic communication of protected health information (PHI).

Complete information regarding Privacy and Security Practices is available to all patients upon individual request and such information is entitled “*Statement of Privacy and Security Practices*”.

Individual Patient Rights: You have rights with respect to the following:

- To read and understand this privacy and security notice prior to treatment
- To request a copy of “Statement of Privacy and Security Practices”
- To expect that all protected health information be utilized only for the following purposes:
 - Treatment (including contacting you with regards to appointment and other treatment related communication)
 - Payment
 - Health care operations
 - Mailing or other communication with you in the form of announcements and/or newsletters
- To request a copy of your personal health information
- To request revision of inaccuracies in your personal health information
- To restrict how your personal health information is used and disclosed except as noted above

Further Information/Concerns: Please express any concerns you may have regarding any violation of your privacy rights, and other privacy and security issues to the Delta Physical Therapy Compliance Officer. Any concerns reported will not result in retaliation or retribution.

Compliance Officer: Kelly Sanders
805 Aerovista, Suite # 201
San Luis Obispo, CA 93401
Email: kelly@spsportstherapy.com
Ph: (805) 788-0805, ext 216

You also have the right to report any concerns regarding your privacy rights to the Secretary of the US Health and Human Services Department. The Department can be contacted at <http://www.hhs.gov/ocr/hipaa> or by calling (415) 437-8310. By signing below, you acknowledge that you were offered a copy of this form and have read its contents.

Patient / Guardian / Personal Representative Signature

Date



OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize Delta Physical Therapy to treat _____ (minor's name) while I am not present.

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 Delta Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Delta 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' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$65 for a physical therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

CO-PAYMENTS: Per our contacting guidelines, co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a \$25 processing fee.

Patient/Guardian/Responsible Party Signature

Date

Please print name

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. 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. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. 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 have received a web printout of my benefits. I understand that ultimately it is my responsibility to know the extent of my benefits. _____ (please initial)
- Web access is not available, please call _____ for verification of insurance benefits.

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

Please print name

Clinic Representative

Date



Medical Screening Form

Name: _____ Date: _____

CURRENT CONDITION:

Where are you currently having symptoms: _____

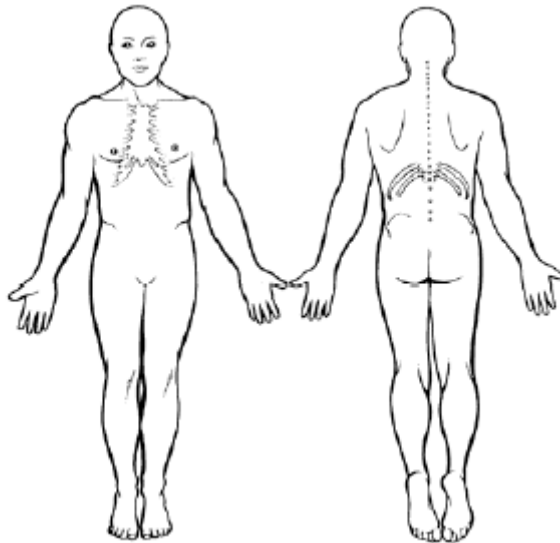
When did these symptoms start? _____

How did this 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 & 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):

- | | | |
|-------------------------|-----------------------|--------------------------------------|
| Unexplained Weight Loss | Difficulty Swallowing | Dizziness |
| Increased Pain at Night | Headaches | Changes in Bowel or Bladder Function |
| Fever / Chills / Sweats | Nausea / Vomiting | Depression |
| Changes in Appetite | Numbness or Tingling | Shortness of Breath |
| | | Poor Balance / Falls |

