



### Returning Patient Form

*Please review the attached copy of the New Patient Form you completed for your last course of therapy. If any of the information is outdated, please make any changes in the appropriate space below. If all of the information on the attached copy is correct, please just fill in your name and check the appropriate box and sign and date at the bottom of this 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 \_\_\_\_\_

Do you currently or have you in the past 6 months had Home Healthcare Services?  Yes  No

Have you been hospitalized in the past 60 days?  Yes  No

If Yes to either question, who is your Home Healthcare Provider: \_\_\_\_\_

Have you had physical and/or speech therapy treatment this year?  Yes  No

If Yes, where? \_\_\_\_\_

How did you hear about us?  Physician  Phonebook  Brochure  Employer  Other \_\_\_\_\_

Injury Type:  Work  Auto  Home  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: \_\_\_\_\_  
ID# Date of Birth Group/Policy #

Secondary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
ID# Date of Birth Group/Policy #

**I am a returning patient and I have updated all necessary information above.**

**I am a returning patient and my information has not changed.**

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](mailto: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

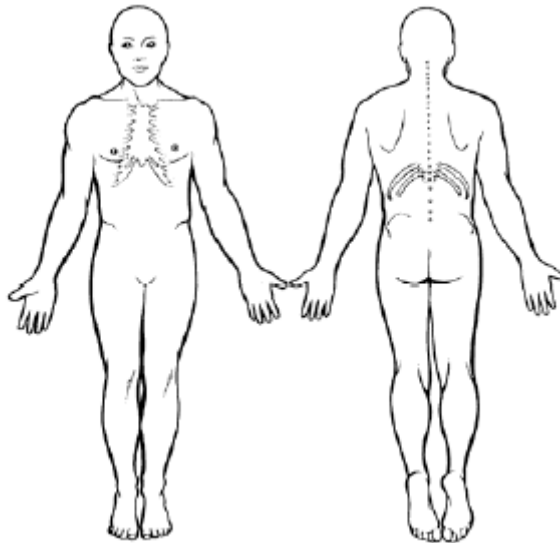
Please list any previous treatment for the condition we are seeing you for today? \_\_\_\_\_

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  
Increased Pain at Night  
Fever / Chills / Sweats  
Changes in Appetite

Difficulty Swallowing  
Headaches  
Nausea / Vomiting  
Numbness or Tingling

Dizziness  
Changes in Bowel or Bladder Function  
Depression  
Shortness of Breath  
Poor Balance / Falls

