

PILLSBURY PHYSICAL THERAPY

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Magalia, CA 95954
Tel: 530.873.2818
Fax: 530.873.2839

2623 Forest Ave
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Tel: 530.343.2778
Fax: 530.343.2738

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Oroville, CA 95966
Tel: 530.533.4199
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PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Gender: Male Female Birthdate: ____/____/____ Age: ____ Marital Status: _____
Address: _____
City: _____ Home Phone: _____
State: _____ Zip _____ Cell Phone: _____
Email: _____ Best # to reach you? Home Cell
Social Security: _____-_____-_____
What is your preferred form of communication? Phone Text Email

Emergency Contact:

Name: _____ Phone: (____) _____ Relationship: _____
I give permission to discuss my medical information with the following:
Name _____ Relationship _____
Name _____ Relationship _____

Referring Physician: _____ Phone: _____
Family Physician: _____ Phone: _____
Employment Status: Employed Retired Unemployed

INSURANCE INFORMATION

Primary Insurance: _____ Insured: Self Other
Secondary Insurance: _____ Insured: Self Other
If other, name insured: _____ Relationship: _____ DOB: ____/____/____

Are you currently enrolled in home health? yes no
Have you received Physical Therapy already this year? yes no

Date of Injury/Onset of Symptoms: ____/____/____
Type of Injury: Work Auto Other
Attorney Involved: yes no
Name of Attorney: _____ Phone: (____) _____

Other than your doctor, how did you hear about us?

Patient Friend/Family Yellow Pages Beyond Fitness Member Website Other: _____

Patient Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

(Effective September 1, 2013)

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

USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operation:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved In Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for worker's compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional facility or law enforcement official. **For Marketing Purposes:** Any uses or disclosures of your health information for marketing purposes, or disclosures that constitute a sale of your protected health information, will require your direct authorization prior to action. **Regarding Genetic Information:** We are prohibited from using or disclosing your protected health information that contains your genetic information for any underwriting purposes. **Other disclosures not listed above:** Any uses or disclosures not described above will be made only with your direct authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time. **Your Right to Restrict Disclosures:** You have a right to restrict certain disclosures of your personal health information to your health plan regarding services that you pay out of pocket in full for (self-pay). **You're Right to Notification of Breaches:** If your personal information is affected by a breach of security at one of our clinics, you have a right to be notified of said breach, as well as the details surrounding the breach.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature

Date

Pillsbury Physical Therapy, Inc. Medical Screening Form

Name: _____ Date of Birth: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Do you use tobacco? **Yes No**

Do you have a pacemaker? **Yes No**

Are you under any abnormal stress? **Yes No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **Yes No**

ALLERGIES: List any medication(s) you are allergic to: _____

Leisure activities, including exercise routines: _____

Occupation and activities: _____

Are you on a work restriction from your doctor? **Yes No**

Please indicate if you are having any difficulty with: Hearing / Speech / Vision / Communication

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> recent infection |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> unexplained weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> trauma of any kind | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|---|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> gastrointestinal problems | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | |
| <input type="checkbox"/> chemical dependency | <input type="checkbox"/> pelvic inflammatory disease | |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure |
|---------------------------------|-----------------------------------|--|

During the past month have you been feeling down, depressed or hopeless? **Yes No**

During the past month have you been bothered by having little interest or pleasure in doing things? **Yes No**

Is this something with which you would like help? **Yes Yes, but not today No**

Have you ever taken steroid medications for any extended period of time? **Yes No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes No**

Are you currently taking any medication for pain? **Yes No**

Have you experienced any falls in the past year? **Yes No**

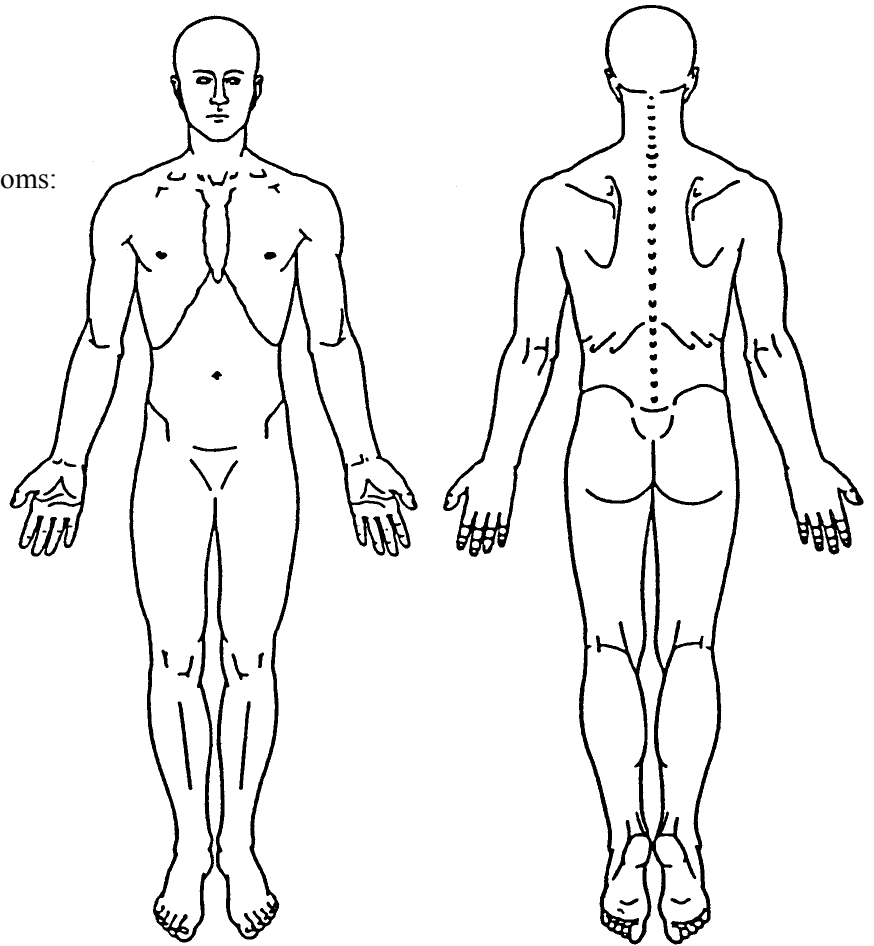
Were you injured? **Yes No**

If you have fallen, how many times have you fallen in the past year? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ **Shooting pain**
- X **Sharp pain**
- O **Dull/aching pain**
- /// **Throbbing pain**
- ||| **Numbness**
- = **Tingling**



Please list any surgeries, including dates:

1. _____
2. _____
3. _____

My symptoms currently: **Come and go** / **Are constant** / **Are constant, but change with activity**

What date (approximately) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: **Getting Better** / **Getting Worse** / **Staying about the same**

I should not do physical activities that might make my pain worse: **Disagree** / **Unsure** / **Agree**

Prior to the onset of your current symptoms, were you limited with any of your usual activities? **Yes** **No**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: **Yes** **No** When _____ Treatment rec'd _____

I would rate my overall health as: **Excellent** / **Good** / **Fair** / **Poor**

For Staff: Last Name: _____ Date of Birth: _____

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

CONSENT FOR CARE & TREATMENT OF A MINOR: As parent and/or legal guardian (choose one) of _____, (patient's name) I understand that a Physical Therapist will complete an evaluation by examination and interview. An 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 **Pillsbury Physical Therapy, Inc.** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating the minor listed above while I am not present.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Pillsbury Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

ASSIGNMENT OF MEDICARE BENEFITS & RELEASE OF INFORMATION: By signing below, I request that payment of authorized Medicare benefits be made on my behalf to: **Pillsbury Physical Therapy, Inc.** for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF SECONDARY INSURANCE BENEFITS (medi-gap) & RELEASE OF INFORMATION: By signing below, I request that payment authorized medi-gap benefits be made on my behalf to **Pillsbury Physical Therapy, Inc.** for any services furnished to me by this provider. I authorize any holder of medical information to release to: _____ (name of secondary insurer) any information needed to determine these benefits or the benefits payable for related services.

WORKER'S COMPENSATION CLAIMS: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. We require that arrangements for payment of your estimated share of cost be made today. You are responsible for your bill. 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 collection 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 and you agree to pay your portion of this bill. We assume no liability for any errors made by your insurance carrier in this quotation.

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

Patient / guardian / Responsible Party

Date: _____

Clinic Representative

Date: _____

Appointment Cancellation and No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, we ask that you call at least **24 hours** prior to your scheduled appointment if you are unable to attend. This allows the ability to offer that appointment time to another patient.

Failure to keep your scheduled appointment may result in a **\$75.00** fee. This fee cannot be billed to your insurance company. This fee will be your responsibility.

We understand that delays can happen, however we must try to keep other patients and therapists on time. **If a patient arrives more than 15 minutes late past their scheduled appointment time, we may have to reschedule the appointment.**

Patients who do not show for their appointment without calling to cancel will be considered as a **NO-SHOW**. Patients who no-show for two (2) or more visits in a 12 month period may be dismissed from the practice. If there are any appointments scheduled after the 2 no show appointments, we may cancel any future visits that were scheduled.

Thank you for your understanding and compliance to our appointment cancellation and no show policy.

I understand Pillsbury Physical Therapy's appointment and cancellation policy and my financial responsibility.

Patient Signature

Date