Adjust Physical Therapy
moving you forward

5950 Santo Rd, Suite D, San Diego, Ca 92124 Ph.: 858-715-3878 Fax: 858-715-3879

NEW PATIENT INFORMATION

PLEASE FILL OUT **ALL** THE INFORMATION AND PROVIDE YOUR INSURANCE CARD AND DRIVER'S LICENSE FOR COPYING

Patient Name:	**Sex:**	**Date of Birth:**	**Age:**
Social Security Number:	**Employment Status:** Employed Unemployed Retired Student	**Marital Status:** Single Married Divorced Widowed	
Residential Address:			
Mailing Address: (if different than above)			
Home Phone:	**Cell Phone:** **Text Reminders:** Yes or No	**E-mail Address:** **E-mail Reminders:** Yes or No	
Employer:	**Occupation:**		
Employer Address:			
Referring MD:	**MD Address:**	**MD Phone:**	
Attorney: (if applicable)	**Attorney Address:**	**Attorney Phone:**	
Financial Party: (Tricare/Tricare 4 Life Dependents ONLY)	**Relationship:**	**Social Security Number:** (Sponsor SSN)	**Date of Birth:** (Sponsor DOB)
Home Phone:	**Cell Phone:**	**Employer:**	
Emergency Contact:	**Relationship:**	**Home Phone:**	
Insurance Company:		**Insurance Phone:**	
Adjuster Name: (if applicable)	**Claim Number:**	**Date of Injury:**	**Date of Surgery:**

In signing below, I agree to be treated by the staff of Adjust Physical Therapy. I understand that I am financially responsible to Adjust Physical Therapy for all unpaid balances. I authorize the release of medical information necessary to process claims for services rendered by Adjust Physical Therapy. I authorize payment of medical benefits to Adjust Physical Therapy.

_____ _____

Signature: Date:

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MEDICAL HISTORY

Name _____ Age _____ Today's Date _____

Do you have a history of the following problems? Please explain if answer is yes.

High blood pressure	Yes	No	_____
Elevated cholesterol level	Yes	No	_____
Irregular heart beats	Yes	No	_____
Heart trouble	Yes	No	_____
Cardiac pacemaker	Yes	No	_____
Circulation trouble	Yes	No	_____
Fever/chills	Yes	No	_____
Numbness	Yes	No	_____
Weakness	Yes	No	_____
Night pains/sweats	Yes	No	_____
Malaise	Yes	No	_____
Unexplained weight change	Yes	No	_____
Dizzy spells	Yes	No	_____
Diabetes	Yes	No	_____
History of smoking	Yes	No	_____
Prolonged cough	Yes	No	_____
Wheezing	Yes	No	_____
Asthma	Yes	No	_____
Hearing problems	Yes	No	_____
Vision problems	Yes	No	_____
Sweating associated with pain	Yes	No	_____
Swelling of extremities	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Nausea/heart burn	Yes	No	_____
Vomiting	Yes	No	_____
Specific food intolerance	Yes	No	_____
Constipation or diarrhea	Yes	No	_____
Rectal bleeding	Yes	No	_____
Change in color of stool	Yes	No	_____
Incontinence	Yes	No	_____
Difficulty urinating	Yes	No	_____
Change in urinating patterns	Yes	No	_____
Blood in urine	Yes	No	_____
Metal implants (other than teeth)	Yes	No	_____
Other physical ailment	Yes	No	_____
Women only:			
Absent/Irregular menstruation	Yes	No	_____
Are you pregnant	Yes	No	_____

Have you received previous treatment for this condition? _____

Have you received previous physical therapy for another condition? _____

Please list any medications	Please list surgeries & dates	Please list any allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please fill out other side

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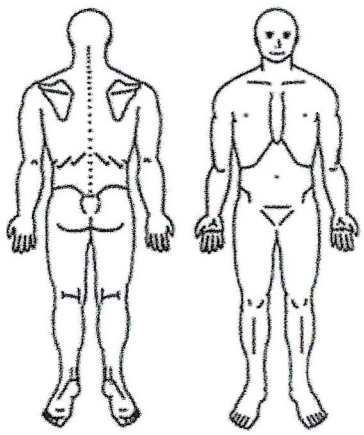
PATIENT QUESTIONAIRE

Your therapist will review this questionnaire. If you do not understand a question, please leave it unanswered.

Occupation: _____

1. Describe your problem (why you came to physical therapy)

2. On the body picture, please shade in the areas which contributes to your pain/discomfort.



3. Do you have any tingling?
   □ Yes □ No If yes where: _____

4. Do you have any numbness?
   □ Yes □ No if yes where: _____

5. A. What makes your condition worse?
(for example: sitting for 15 minutes, walking up stairs, looking over your shoulder when driving, etc.)

B. What eases/improves your condition (for example: lying on your right side.)

6. Does your condition disturb your sleep? □ Yes □ No
   How was your condition first thing this morning? □ Worse □ Better □ Same
   How is your condition at the end of the day? □ Worse □Better □ Same

7. What was your problem first noticed? Date:

8. What caused your problem? □ No reason □ Reason (injury, exercise) Please explain:

9. Is your problem getting: □ Better □ Worse □ Staying the same

10. Are you □ currently employed □ on leave □ not working because of condition
    If off work, since when?

11. What activities are you presently unable to do because of this problem?

12. Is litigation (legal counseling) involved? □ Yes □ No

13. How you describe your general health? □ Good □ Fair □ Poor

14. What do you hope to accomplish in physical therapy? (What are your goals?)

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FINANCIAL AGREEMENT

Your doctor has referred you for physical therapy. Physical therapy is often an ongoing process that requires regular attendance to be effective. We encourage you to follow all orders by your doctor.

We are committed to providing you with the best possible care. In order to help you achieve your maximum allowable benefits from you medical insurance, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time of service unless payment arrangements are approved in advance by our staff. We accept cash, checks and credit cards (Visa/MasterCard). We will be happy to help you process your insurance claim form for your reimbursement. If you would like us to bill your insurance we must have and assignment of benefits; we will collect your deductible and copayments the day of each visit.

Please keep in mind that patients are responsible for knowing their insurance benefits and there are certain types of insurances that will have a deductible and/or out-of-pockets costs that need to be met before the insurance will take over and cover a percentage. Before that amount is met the patient will be responsible to pay for treatments out of pocket in accordance to their insurance based on the fee plan established within your plan. If you have any concerns about your insurance and what will be covered, you will need to call the customer service number located on the back of your insurance card.

If you would like to bill your own insurance, payment will be due at the time of service, and a receipt will be provided so that you may file for your own reimbursement. If you are covered by Workman's Compensation Insurance, be advised that you may be held responsible for your charges in the event your claim is denied/unpaid.

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I understand that my insurance is a contract between me, my insurance and/or my employer. Adjust Physical Therapy is not part of that contract. (Please be advised, if for any reason, your insurance company pays less than the percentage stated in your contract, you are responsible for the difference).

If any payments made directly to me for services billed by Adjust Physical Therapy, I understand I am obligated to promptly remit the same to Adjust Physical Therapy with a copy of the Insurance Explanation of Benefits.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will also be responsible for all costs of collecting monies owed, including court costs. I realize that returned checks are subject to a $10 fee in addition to the immediate cash payment for services rendered.

I agree that I am to give a **24 hours** advanced notice if I am unable to make my scheduled appointment, or there will be a **$35** charge due at my next appointment.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT.
I UNDERSTAND THAT I AM TO PAY ANY DEDUCTIBLE, COPYAMENT OR OTHER CHARGES NOT COVERED UNDER MY INSURANCE.

Signed: _____ Date: _____ Witness: _____

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NOTICE OF PATIENT INFORMATION PRACTICES

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

ADJUST PHYISCAL THERAPY'S LEGAL DUTY

Adjust Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Adjust Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Adjust Physical Therapy May also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our' policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

Adjust Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of out Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review of obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have that right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Adjust Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access of disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Adjust Physical Therapy
Attn: Brian McDonald, Privacy Officer
5950 Santo Road, Suite D, San Diego, Ca 92124
Phone: 858-715-3878 Fax: 858-715-3879

PATIENT INFORMATION CONSENT FORM

I have read and fully under Adjust Physical Therapy's Notice of Information Practices. In understand that Adjust Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Adjust Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Adjust Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Print Name

_____

Signature

_____

Date

I also authorize Adjust Physical Therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____

Print Name

_____

Signature

_____

Date