



Patient Information

Date: _____

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

Sex: _____ DOB: _____ Age: _____ SS#: _____

D.L.#: _____ Email: _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work #: _____

Occupation: _____

Emergency Contact: _____ Phone #: _____

Referring Physician/Provider: _____

How did you hear about us? _____

Insurance Information

Primary _____ Secondary _____

Policy #: _____ Policy #: _____

Member #: _____ Member #: _____

Group #: _____ Group #: _____

Insurance Phone #: _____ Insurance Phone #: _____

Insurance Address: _____ Insurance Address: _____

Co-pay Amount: _____ Co-pay Amount: _____

For Office: Cross-reference Insurance Information with Insurance Benefit Verification.

Name: _____ SSN: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? 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: _____

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"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> 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"/> falls | <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"/> tuberculosis | <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"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

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"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

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

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) 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

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

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

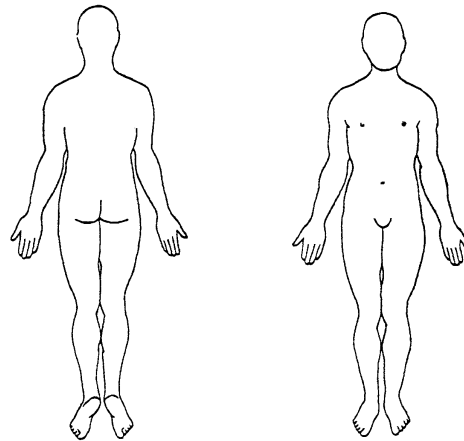
Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

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/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



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

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____



Notice of Information Practice

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION

Table Mountain Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting the internal administrative activities and evaluating the quality of care that we provide. For example Table Mountain Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment or other health related benefits that may be of interest to you. Table Mountain Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or incidental disclosures. We also provide information when required by law. In any other situation, Table Mountain Physical Therapy's 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 disclosures at any time. Table Mountain Physical Therapy's may change its policy at any time. When changes are made, a new Notice of Patient 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 our Notice of Patient of Information Practice at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any accurate or incomplete information in your records. You also have the 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. Table Mountain 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 Table Mountain Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of our personal information, please contact our practice manager at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Table Mountain Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Table Mountain Physical Therapy
James Plummer, PT
2000 Fifth Avenue, Oroville, CA 95965
530-533-2233

Signature constitutes acceptance of above policies

Patient's signature _____ Date _____



Financial Policy and Patient Responsibility:

Table Mountain Physical Therapy is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy. If you have any questions, please do not hesitate to discuss them with us.

It is the patient's responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment and/or deductible at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in Claims payment by contacting their insurance carrier when claims have not been paid.
- If med-pay applies (i.e. auto insurance or personal injury), it is their responsibility to know their limit, how much has been used and how much is available.

Payment can be cash or check. If the bank returns a check there will be a Bank Service Charge and Return Check Charge of up to 3 times the amount of check. _____ (patient initials).

It is Table Mountain Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Attendance Policy: At Table Mountain Physical Therapy, our patients spend an entire hour working one-on-one with a physical therapist (not an aide or an assistant). We find that this practice generally results in a decrease in the time needed to resolve your problem. Because of this, we ask that if you must cancel an appointment, call at least 24 hours in advance.

You will be charged \$20 if you fail to do so. _____ (patient initials).

Financial Policy Acknowledgement and Authorization to Evaluate and Treat

As a courtesy to you the insured, Table Mountain Physical Therapy will verify insurance benefits and coverage. This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for any services rendered. The patient, or legal guardian, is liable for all charges not covered by insurance, whether or not such coverage agrees with the estimated amount. The patient, or legal guardian, is also responsible for charges if the insurance carrier denies the claim or deems that the treatment provided is not medically necessary. As stated above, if med-pay applies, it is your responsibility to know your limit, how much has been used and how much is available. I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

I hereby authorize Table Mountain Physical Therapy to evaluate and treat my condition(s).

_____/_____/_____
Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Table Mountain Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Table Mountain Physical Therapy.

_____/_____/_____
Patient or Responsible Party Signature Date