TABLE MOUNTAIN PHYSICAL THERAPY

# Patient Information

**Date:** _____

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

**Sex: (circle)** **M / F** **DOB:** _____ **Age:** _____ **SS#:** _____

**D.L.#:** _____ **Email:** _____

**Address:** _____ **City/State/Zip:** _____

**Home Phone #:** _____ **Cell Phone #:** _____

**Employer:** _____ **Work #:** _____

**Occupation:** _____

**Emergency Contact:** _____ **Rel:** _____ **Phone #:** _____

**Referring Physician/Provider:** _____

**How did you hear about us?** _____

# 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 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 inaccurate 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**
Dr. James Plummer, PT, DPT, OCS, SCS
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 48 hours in advance. **You will be charged $50 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

TABLE MOUNTAIN PHYSICAL THERAPY

# Attendance Policy

**Please read thoroughly:**

Table Mountain Physical Therapy aims to provide you with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for you with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your attendance and commitment to the planned treatment program are paramount to your full recovery.

We recognize that emergencies may occur in rare instances. Missed appointments prolong your recovery, negatively impact your therapist's schedule and create barriers to patients in need of pain relief. These cancellations, especially last minute ones, decrease our ability to accommodate the scheduling needs of the other patients. We ask for your cooperation with the following policy:

- If you are late by more than 30 minutes your appointment and fail to notify us, treatment may be cancelled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 48 HOURS IN ADVANCE. A fee of $50 may be charged if sufficient notice is not given.
- Failure to show up for an appointment ("No Show") without notifying us will also result in a fee being charged for that appointment.
- 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments. This will require a new order from your provider to continue.
- You may be discharged after three cancellations with or without notice.
- All cancellations and no-shows are documented in your medical record. If there is pending litigation or a worker's compensation claim, this may negatively affect your case.

Note: If you are covered under a lien or worker's compensation insurance, it is your responsibility to make sure you keep all appointments. Claims adjusters track your appointments and are aware of late arrivals, cancels and no-shows. Your attendance record will affect your claim.

I have read and agree to comply with the attendance policy described above.

_____
Patient's Name

_____ _____
Patient's Signature Date

**Name:** _____ **SSN:**_____ **Date:**_____

**Leisure activities, including exercise routines:**_____

**Occupation, including activities that comprise your workday:**_____

**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:** _____

**FOR MEDICARE PATIENTS: Have you had any type of Home Health Care in the last 30 days? Yes No**

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

| | | |
|---|---|---|
| ❑ fatigue | ❑ numbness or tingling | ❑ constipation |
| ❑ fever/chills/sweats | ❑ muscle weakness | ❑ diarrhea |
| ❑ nausea/vomiting | ❑ dizziness/lightheadedness | ❑ shortness of breath |
| ❑ weight loss/gain | ❑ heartburn/indigestion | ❑ fainting |
| ❑ difficulty maintaining balance while walking | ❑ difficulty swallowing | ❑ cough |
| ❑ falls | ❑ changes in bowel or bladder function | ❑ headaches |

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

| | | |
|---|---|---|
| ❑ cancer | ❑ depression | ❑ thyroid problems |
| ❑ heart problems | ❑ lung problems | ❑ diabetes |
| ❑ chest pain/angina | ❑ tuberculosis | ❑ osteoporosis |
| ❑ high blood pressure | ❑ asthma | ❑ multiple sclerosis |
| ❑ circulation problems | ❑ rheumatoid arthritis | ❑ epilepsy |
| ❑ blood clots | ❑ other arthritic condition | ❑ eye problem/infection |
| ❑ stroke | ❑ bladder/urinary tract infection | ❑ ulcers |
| ❑ anemia | ❑ kidney problem/infection | ❑ liver problems |
| ❑ bone or joint infection | ❑ sexually transmitted disease/HIV | ❑ hepatitis |
| ❑ chemical dependency (i.e., alcoholism) | ❑ pelvic inflammatory disease | ❑ pneumonia |

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

| | | |
|---|---|---|
| ❑ cancer | ❑ diabetes | ❑ tuberculosis |
| ❑ heart problems | ❑ stroke | ❑ thyroid problems |
| ❑ high blood pressure | ❑ depression | ❑ 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**

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**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**

**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?** _____

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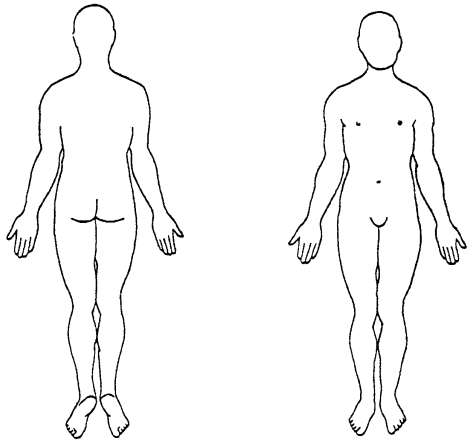
**Body Chart:**

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**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



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

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**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

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**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: _____