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**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_Zip code: \_\_\_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Sex:  Male  Female

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip code: \_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to patient:

**Authorization to Treat a Minor:**

This consent shall remain effective until discharged from Physical Therapy unless revoked in writing.

I, the undersigned parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, does herby Authorize and consent to any medical treatment rendered under the general or special supervision of any member of the medical staff licensed under the provision of the American Physical Therapy Association. It is understood the this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, with the aforementioned Physical Therapy in the exercise of the best judgment may deem advisable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Name Signature Date

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**Initial: \_\_\_\_\_ ASSIGNMENT OF BENEFITS :** I hereby authorize, South Bay Rehabilitation and/or

Rossmoor Rehabilitation to furnish my insurance carrier(s) any and all requested

information concerning my health care.

I also authorize my insurance carrier(s) to pay South Bay Rehabilitation and Rossmoor Rehabilitation, directly for services rendered. If my insurance carrier does not provide payment for my treatments to South Bay or Rossmoor Rehabilitation, I understand that I am fully responsible for any denied and/or unpaid claims.

Primary Insurance Company / ID #: Secondary Insurance Company / ID #:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial: \_\_\_\_\_ ACKNOWLEDGEMENT OF BENEFITS:** I acknowledge having received and signed

A copy of my “verification of benefits” for physical therapy which outlines any financial

responsibilities I may incur for services rendered at South Bay Rehabilitation and/or

Rossmoor Rehabilitation.  By signing this statement below I acknowledge that these benefits

have been explained to me and I understand them completely. If not, please ask the front

office to explain any financial responsibility you may incur.

**Initial:** \_\_\_\_\_ **CANCELLATION AND “NO SHOW” POLICY:** **“No-Shows” and**

 **cancellations with less than 24 hours’** notice prior to scheduled appointments

will be charged **$50.00**. This charge is the patient’s responsibility and cannot be billed to your insurance company. Patients who no-show three times, pending extenuating circumstances, are limited to scheduling on the day of treatment only (no pre-scheduling) and must have all outstanding balances paid to date to continue in therapy. **Notice to Worker’s Comp patients**: **Two No-Show appointments will result in automatic discharge**. Please be courteous and cancel all appointments with appropriate advanced notice. This will help our office maintain our quality standards and avoid any scheduling difficulties.

**Please schedule your appointments in advance to set your sessions at a preferred time and maintain your primary therapist.**

**\*Failure to initial does not exclude you from our policy\***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**

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Name: South Bay Rehabilitation Rossmoor Rehabilitation

Address: 23133 Hawthorne Blvd, Suite 104 12501Seal Beach Blvd, Suite 210

 Torrance, CA 90505 Seal Beach, Ca. 90740

Telephone: 310.373.3181 562.493.8800

Contact Person: Andrew Ochs

**PATIENT CONTACT INFORMATION/RESTRICTION**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of their home. I wish to be contacted in the following manner (check all that apply):

I, , have received a copy of this Office’s Notice of Privacy Practices.

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Home Telephone**

* O.K. to leave message with detailed information.
* Leave message with call back number only.

**Work Telephone**

* O.K. to leave message with detailed information.
* Leave message with call back number only.

**You have the right to refuse to sign this document**

**FOR OFFICE USE ONLY**

This Office attempted to obtain written acknowledgment of receipt of the **NOTICE** of Privacy Practices. However, we were unable to obtain it because:

 The patient refused to sign.

 Communication barriers prohibited obtaining the acknowledgment.

 An emergency situation prevented this office from obtaining the acknowledgment.

 Other (see below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please take a moment to answer the following questions. This will help your therapist determine the most appropriate individual treatment program.

1. Patient Name:

2. Age: Height: Weight:

Date: Handedness: Right/Left

 3. Occupation/Sport

 4. What is your injury/chief complaint?

 a. When did your injury occur/when did you first notice symptoms?

 b. How did your injury occur/what is possible cause of

symptoms?

c. Is this work related?

5. Type of symptoms/pain you are experiencing:

⬜ Intermittent ⬜ Constant

⬜ Sharp ⬜ Shooting ⬜ Aching ⬜ Burning ⬜ Deep ⬜ Diffuse ⬜ Localized

⬜ Numbness ⬜ Tingling Other:

6. Rate you pain level by circling appropriate number:

*LESS PAIN* 1 2 3 4 5 6 7 8 9 10 *MORE PAIN*

7. In the past 30 days, have your symptoms/pain: increased/decreased/remained the same

8. What types of activities do you have difficulty with?

⬜ Walking ⬜Standing ⬜ Sitting ⬜ Driving ⬜ Transitioning from sit to stand ⬜ Lifting

⬜ Bending ⬜ Reaching ⬜ Dressing ⬜ Grooming ⬜ Bathing ⬜ Toileting

Other

9. Are there any activities or positions that make your symptoms

*worse*? If so explain:

10. Are there any activities or positions that make your symptoms

*better*? If so explain:

11. Have you had any imaging of the affected area?

⬜ X-Ray ⬜MRI ⬜CT ⬜ Other

Results (if known)

12. Have you had or are you receiving alternative treatment for this ailment (this includes previous physical therapy, acupuncture, chiropractic care)? ⬜ Yes ⬜ No

a. If yes, please describe treatment and response to treatment

 13. Do you have any other medical conditions/diseases? ⬜ Yes ⬜ No

Please check all of the following that apply

❏ Anemia

❏ Aneurysm

❏ Angina (chest pain)

❏ Asthma

❏ Balance Deficits/Fall History

❏ Blood Pressure

High/Low

 /

❏ Cancer

❏ Cardiovascular disease

❏ CVA/Stroke

❏ Diabetes Type

1/Type 2

❏ Epilepsy

❏ Fibromyalgia

❏ Hernia

❏ Lupus

❏ Neurological

Deficits

❏ Osteoarthritis

❏ Osteopenia

❏ Osteoporosis

❏ Pulmonary

Embolism

❏ Respiratory

Infections

❏ Rheumatoid

Arthritis

❏ Thyroid Disorder

❏ Vertigo/Dizziness

❏ Other

14. Please explain history of above checked medical

conditions:

15. Previous surgeries (procedure and date):

16. Current medications (please name below or provide list):

17. Allergies: (Please note if you have an allergy to cortisone or latex)

18. Are you pregnant? ⬜ Yes ⬜No

19. When is your next appointment with the doctor that referred you to physical therapy?

Date

Time

20. Do you have a primary care physician? ⬜ Yes ⬜No

Physician Name

City

Phone

**ATTENTION MEDICARE PATIENTS:**

**a. Are you currently receiving or have you recently received any form of HOME HEALTH CARE in the past year including physical, occupational, speech therapies or nursing care?** ⬜ ***Yes*** ⬜ ***No***

**b. Have you assigned your Medicare Part B benefits over to a HMO (We do not** **accept Medicare HMO)?** ⬜ ***Yes*** ⬜ ***No***