

ALAMITOS PHYSICAL THERAPY ASSOCIATES

5122 Katella Avenue, Suite 16 * Los Alamitos, CA 90720
(562) 795-5295 * (714) 761-1491 * Fax: (562) 795-5297
AlamitosPhysicalTherapy.com * Facebook.com/AlamitosPT

Today's Date: _____

Patient Name: _____ M () F ()
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birthdate: ____/____/____ Age: _____ Drivers License/ID#: _____

SSN: _____ Marital Status: _____ Spouses Name: _____

Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Primary Care Physician: _____ Phone: _____

What are we seeing you for? _____

Date of Injury (if applicable): _____ Date of Surgery (if applicable) _____

How were you referred here? _____

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

PLEASE SUBMIT YOUR INSURANCE CARD(S) AND DRIVERS LICENSE OR ID.

If patient is a minor, name of parent/guardian: _____

Phone: _____ Birthdate: _____ Relationship: _____

Are you on Facebook? _____ Send us a "friend request" or "like us"

Patient History

Federal regulations require a medical history must be included in all patient medical records. This will assist us in properly treating you and identifying possible contraindications for treatment.

Name: (first, middle & last) _____ Ht: _____ Wt: _____

Date of Birth: _____ **Please Circle:** L- Handed, Rt-Handed, or Ambidextrous

Are you currently receiving Home Physical Therapy/ other Home Care treatments? Yes No

Have you received Physical Therapy or Speech Therapy this year? Yes No, If yes, how

many? _____ *If yes to the last 2 questions, please talk with the person at the front desk, before continuing.*

General Health: good, fair, poor; Use of Alcohol Yes No; Use of tobacco Yes No

Chief Complaint? Treatment area? (Briefly describe injury or how and when complaints began): _____

Rate your complaint in order of severity (1= worst, 5 least; circle if applicable and NA if not)

Pain, Numbness, Tingling: _____

Loss of function: _____ What function(s): _____

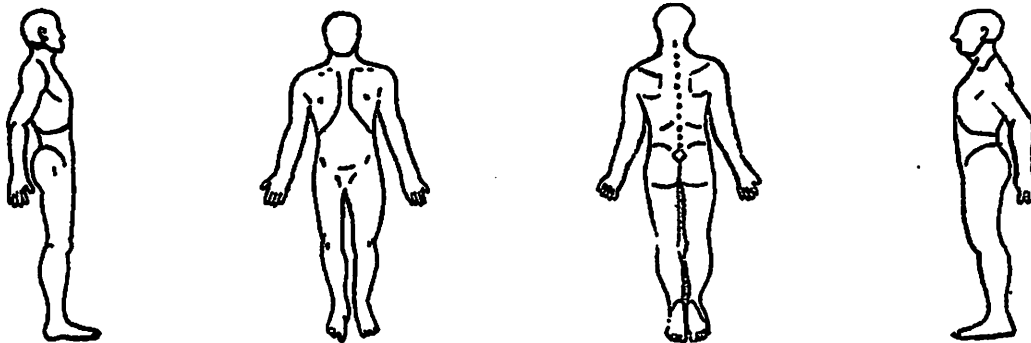
Stiffness/Decreased motion: _____ where: _____

Difficulty walking/ Balance problems/Falling: _____; how many falls? _____ (due to meds, home hazard, BP, Vision)

Swelling/edema: _____ Where? _____

Other: _____

Where is your problem? Indicate on body chart: Pain = xxx, Numbness=ooo, Tingling= ###



Describe your pain and symptoms: Sharp, Dull ache, Piercing, Shooting, Deep, Superficial, Burning, Stabbing, Intermittent, Constant

What makes your symptoms worse?(please circle): walking, standing, sitting, kneeling, bending, squatting, reaching up/behind, up- down stairs, lying down, bowel/bladder function, getting up from sitting or lying down, other?) _____

better? (rest, heat, cold pak, meds, other) _____

Rate your pain (0= no pain, 10= emergency)Now: _____ Initial at time of onset: _____

Worst it has been: _____ Past 2-4weeks _____ Last 24hrs _____ Best or least _____

Are your symptoms: Improving _____ Worse _____ Stable _____
 Are your symptoms worse in _____ morning, _____ afternoon, _____, evening,
 _____ inconsistent/ no pattern
 Do your symptoms wake you up? Yes ___ No ___ Do you sleep in a ___ bed, ___ recliner, ___ other
 Do you wake up at night? How many times? _____ Why? _____

Did you have surgery for this problem? Type: _____ Date of Surgery: _____
 Did you have Physical Therapy previously for the condition? Yes ___ No ___ When? _____
 Results: _____

Other surgeries (*list and dates*) – use back side if needed

Hospitalizations (*condition and dates*) - use back side if needed

Has this problem affected your daily life or routine?

Have you had any special tests for this condition (X-Rays, MRI, CT Scan, other)? When and Results? _____

Do you have reports? If yes, please provide: _____

Have you received treatments for this current problem? (**Circle Discipline and results**)

Acupuncture, Doctor's visit (medications, injections, other), Chiropractor, Massage

Other: _____

Results: _____

Please answer the following: (<i>Please circle and explain below</i>)	Yes	No
a. Do your symptoms change with cough or sneeze?	___	___
b. Have you had any changes in bowel or bladder function?	___	___
c. Do you experience any dizziness or vertigo?	___	___
d. Have you had any recent change in your weight or appetite? (<i>Increase/decrease</i>)	___	___
e. Do you have any intolerance to hot or cold?	___	___
f. Do you have any bleeding or bruising disorders? Blood clots?	___	___
g. Have you had any skin changes, such as rashes or discoloration, infections?	___	___
h. Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual field? Hearing Impairment?	___	___
i. Have you had had a recent episode of nausea or vomiting?	___	___
j. Do you have Osteoporosis? Osteopenia?	___	___
k. Have you noticed any shortness of breath or decrease in exercise tolerance?	___	___
l. Do you have a history of neck or back problems?	___	___
m. Do you have a loss of sensation? Where?	___	___

Do you have or had any of the following:

- | | | | |
|-----------------------------|----------------|------------------------------------|----------------|
| 1. Diabetes 1 or 2 (circle) | Yes ___ No ___ | 17. Autoimmune Diseases | Yes ___ No ___ |
| 2. High Blood Pressure | Yes ___ No ___ | 18. Pregnant currently | Yes ___ No ___ |
| 3. Heart Disease/Arrhythmia | Yes ___ No ___ | 19. Neuromuscular Disorder | Yes ___ No ___ |
| 4. Heart Attack | Yes ___ No ___ | 20. Metal Implants | Yes ___ No ___ |
| 5. Pacemaker | Yes ___ No ___ | 21. Cancer | Yes ___ No ___ |
| 6. Congestive Heart Failure | Yes ___ No ___ | 22. Loss of consciousness/fainting | Yes ___ No ___ |
| 7. Stroke | Yes ___ No ___ | 23. Fibromyalgia | Yes ___ No ___ |
| 8. Kidney Problems | Yes ___ No ___ | 24. Hernia (ventral or inguinal) | Yes ___ No ___ |
| 9. Liver Problems | Yes ___ No ___ | 25. Tape Allergies | Yes ___ No ___ |
| 10. Breathing Problems | Yes ___ No ___ | 30. Latex Allergies | Yes ___ No ___ |
| 11. Digestive Problems | Yes ___ No ___ | 31. Other Allergies (meds, foods) | Yes ___ No ___ |
| 12. Peripheral Neuropathy | Yes ___ No ___ | 32. Psych. Disorder (ADHD, PTSD) | Yes ___ No ___ |
| 13. Depression | Yes ___ No ___ | 33. Anxiety | Yes ___ No ___ |
| 14. Headaches or Migraines | Yes ___ No ___ | 34. Seizures | Yes ___ No ___ |
| 15. Cognitive Impairment | Yes ___ No ___ | 35. Fracture or suspected | Yes ___ No ___ |
| 16. Unexplained Pain | Yes ___ No ___ | 36. Hypo- or Hyperthyroid | Yes ___ No ___ |
| 17. Sleep Apnea | Yes ___ No ___ | 37. Sleep Problems | Yes ___ No ___ |
| 18. TMJ Dysfunction | Yes ___ No ___ | 38. Other: _____ | Yes ___ No ___ |

If yes to any of the above, please explain and give approximate dates: _____

Please provide a list of all Over the Counter and Prescription Medications: _____

Please provide list of vitamins, herbs, essential oils, supplements: _____

Presently Working: ___ Yes ___ No, If no, since _____ Expect to return to work on: _____

Occupation: _____ General Requirements: _____

Physical Work Demand: ___ Very Light, ___ Light, ___ Moderate, ___ Heavy, ___ Very Heavy

Overall activity level: ___ Sedentary, ___ Light, ___ Moderate, ___ Heavy, ___ Very Heavy

Previous exercise/sports/activities (type, frequency, duration): _____

What are your Physical Therapy goals? _____

Do you use any durable medical equipment? (*Please circle*): tub bench, shower chair, raised toilet seat, bedside commode, safety grab bars, standard walker, rolling walker, straight cane, quad cane, wheelchair, crutches; none; other: _____

Anything we missed? _____

I certify that the above information is true and correct to the best of my knowledge

Patient Signature/Guardian: _____ **Date:** _____

ALAMITOS PHYSICAL THERAPY PHOTO/VIDEO RELEASE FORM

I hereby grant Alamitos Physical Therapy permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Alamitos Physical Therapy and will not be returned.

I hereby irrevocably authorize Alamitos Physical Therapy to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Alamitos Physical Therapy from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

Print Name

Signature

Date

If under 18, BOTH PARENTS MUST SIGN.

Individually and as Parent and/
Legal Guardian

Date

Individually and as Parent and/
Legal Guardian

Date

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Informed Consent for Care at Alamitos Physical Therapy Associates (APTA)

Here at APTA, we see a wide variety of conditions. The purpose of physical therapy is to treat disease, injury, dysfunction, and disability by examination, evaluation, diagnosis, prognosis and intervention. We use rehabilitative procedures, mobilization, exercises, and physical agents to aid you in achieving your maximum potential within your capabilities and to accelerate convalescence and reduce the length of functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy varies from person to person. It is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

APTA does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition. Your physical therapist cannot make any promises or guarantees regarding a cure for, or improvements in your condition.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

Benefits may include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, flexibility and endurance.

There is a possibility the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. You may experience an increase in your current level of pain or discomfort, or aggravation of your existing injury during or after your session.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns.

It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.

It is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I wish to proceed with care at APTA.

Name _____ Signature _____ Date _____

**ALAMITOS PHYSICAL THERAPY
ASSIGNMENT OF BENEFITS – CONSENT FOR TREATMENT – FINANCIAL POLICY
NOTICE OF PRIVACY PRACTICES**

THANK YOU FOR CHOOSING ALAMITOS PHYSICAL THERAPY. We are committed to your entire experience here being successful, and we want you to completely understand our financial policies. You have a financial responsibility that obligates you to ensure full payment of your bill.

INSURANCE INFORMATION: We need complete and accurate information about your policy. We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay or coinsurance as determined by your contract with your insurance company. If your insurance company requires you to have a referral from your primary care physician, you will need to have that faxed to our office or brought with you to your appointment. As a courtesy, we will contact your primary care for the referral but it is ultimately your responsibility to make sure the referral is issued. You are responsible for any amount or any services not covered by your insurer.

CHANGES IN COVERAGE: It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company. If your insurance changes, we will bill your new insurance company when we receive your current information, but there is no guarantee they will cover all services.

IN-NETWORK: You are responsible for meeting the in-network deductible before your insurance will begin to pay for services rendered. You are responsible for co-payments and/or coinsurance as specified in your "Schedule of Benefits". Alamitos Physical Therapy has agreed with your insurance company to accept the Preferred Provider maximum allowable charge as full payment for the services rendered. You are responsible to pay for any services that are received but not covered under your policy. Co-pays or deductible are due at the time of service.

WORKERS' COMPENSATION: We must have authorization from the insurance carrier and adjuster in order to begin treatment. The authorization must have our name on it. You also are required to have the referral from your doctor.

MEDICARE: Alamitos Physical Therapy is a Medicare-Approved provider of outpatient physical therapy. All Medicare policy holders have a maximum benefit for outpatient physical therapy services. We will monitor your visits and make you aware as you near the maximum allowed by Medicare. You are responsible to make us aware of any previous treatment you may have had at another facility in the current year. Medicare will not pay for outpatient therapy services while you are receiving home services. It is your responsibility to make sure your home health agency has discharged you from their care.

YOUR STATEMENT: Patient statements will be mailed out monthly. As a courtesy, Alamitos Physical Therapy will submit claims to your health insurance company after each visit, and we will apply payments received to your account. If needed, we will re-submit these claims to ensure payment of your benefit for covered services. In the event that repeated submission of claims does not satisfy your bill for the services rendered, you will be responsible for the full payment of your bill. In addition, any remaining balance after your health insurance has paid is your responsibility.

PAYMENT: We accept cash, check, debit cards. There will be a **\$20.00 service charge for all returned checks**. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, the payment is due upon receipt of a statement from our office. We will work with you to set up customized payment plan if necessary, so please don't hesitate to ask. **I understand that there is a 5% monthly interest charge if my account balance becomes past due (60 days).**

COLLECTIONS: We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to our collection agency and reported to the credit bureau. If payment arrangements are not kept up on a timely basis and your balance, no matter how small the amount, becomes more than 120 days old, we will proceed to send your balance to our collection agency. Should your account be referred to our collection agency, there is a one time \$30.00 charge that will be added.

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical benefits is made on my behalf directly to Alamitos Physical Therapy of all service(s) furnished to me. I authorize Alamitos Physical Therapy to release my medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPPA release of protected health information

standards. In the event that I receive payments from the insurance company, I will forward the payments to Alamitos Physical Therapy by the way of check from my personal account or credit card within 5 business days of receiving the payment.

NOTICE OF PRIVACY PRACTICES: I am aware that I have the right to review Alamitos Physical Therapy's privacy notice and that I may request restrictions or revoke consent at any time.

I have received the Notice of Privacy Practices and have had an opportunity to review it. This Notice describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information. _____(initial if received)

CONSENT FOR CARE/TREATMENT: I authorize Alamitos Physical Therapy personnel to administer care and treatment to me in accordance with my Doctor's prescription/Plan of Care, or other treatment necessary and advisable by the provider who attends me. I also consent to the release of any medical or other appropriate health information required to determine treatment, payment or further care considerations.

APPOINTMENT POLICY: When canceling, you must call at least **24 business hours** in advance of your scheduled appointment as we have reserved the Therapists time on our schedule for you appointment and would appreciate an advanced notice so that another patient could schedule during that valuable time. **A late cancellation fee of \$25.00** will be charged for appointments missed without proper notice. We understand that there are special and unforeseen situations that will be assessed on a case-by-case basis. **If three (3) appointments in a row have been missed, we have the right to discharge you from care.**

REMEMBER, PAYMENTS ARE DUE AT THE TIME OF SERVICE!

I have read and understand the above policies and agree to the conditions listed.

Print Patient Name

Print Name of Person authorized to consent

Signature of Patient or Person Authorized

Date

**ALAMITOS PHYSICAL THERAPY
OUT OF NETWORK POLICY**

Prior to scheduling your appointment, you should have been informed that we do not have a contract with your insurance, therefore payment from your insurance will be under their "out of network" policy. So as to make it more affordable for our patients, we will accept \$150.00 per visit paid by your insurance and you. All deductibles must be met first before this will apply.

Some Blue Cross plans will send the payment directly to the insured. You will need to deposit the check, then provide us cash or a check for that amount. You can also call and do a credit card payment. We must receive the payment within 5 business day from when you receive the payment in order to take advantage of the discount we are offering.

We do receive the Explanation of Benefits (EOB's) from your insurance so we do know the amount, date and check number of the payment. The insurance company also informs us when the check is processed.

Print Patient Name

Print Name of Person authorized to consent

Signature of Patient or Person Authorized

Date