Alamitos Physical Therapy Assoc.
5122 Katella Avenue #16, Los Alamitos, CA 90720
(562) 795-5295 – fax (562) 795-5297
AlamitosPT.com – Email Us: staff@alamitospt.com

Todays Date: ______________________________

Patient Name (Last, First, MI): ____ M( ) F( )

Address/City/State/Zip: ____

Home #: ________________ Cell #: ________________ Email: __________________________________

Birthdate: ______________ Age: _________ Drivers License/ID#: ________________________________

SSN (for insurance): _________________________ Spouse/Partner: ______________________________

Employer: ____ Work #: __________________________

Address/City/State/Zip: ____

Occupation: ____

What are you here for? ____

Date of Injury: ___________________________Date of Surgery: _________________________________

Who referred you? ____

Emergency Contact:

Name: ____

Phone #: ____________________________ Relationship: ______________________________________

Primary Care Physician: _____________________________ Phone #: __________________________

Appointments are verified thru our automated system the day before your scheduled appointment, please select how you would like to be contacted:

Email _____ Cell # _____ Both _____

Are you on any social media? Which ones? ____
Send us a "friend request" or "like us"

Patient/Guarantor Signature: ____

ALAMITOS PHYSICAL THERAPY

INSURANCE INFORMATION

(Please submit your insurance card(s) and picture ID)

Primary Insurance: ____

ID #: ______________________________ Group #: ______________

Subscriber: ___________________________ Birthdate: ______________

Secondary Insurance: ____

ID #: ______________________________ Group #: ______________

Subscriber: ___________________________ Birthdate: ______________

Name of Patient: ___________________________ Birthdate: ___________

Signature of Patient/Guardian: _________________________ Date: __________

Patient History

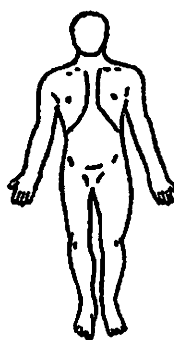
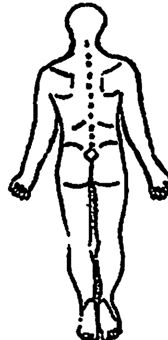
Federal regulations require a medical history must be included in all patient medical records. This will assist us in properly treating you and identifying possible contraindications for treatment.

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: (*Please circle and explain below*)	**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? (Increase/decrease)	___	___
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: ____________

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INFORMED CONSENT FOR CARE AT ALAMITOS PHYSICAL THERAPY ASSOC (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 question 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 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: __________

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AUTHORIZATION TO TREAT A MINOR

I, the undersigned parent or legal guardian of ________________________________, a minor, do hereby authorize and consent to any evaluation and physical therapy treatment rendered by any member of staff licensed under the provisions of the Physical Therapy Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment deemed advisable by the aforementioned physician in the exercise of his best judgment. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient but that none of the above treatment will be withheld if the undersigned cannot be reached.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Consent is given for therapy to be provided when the parent/guardian is not in the facility.

Consent is given to allow the minor to leave the facility when the treatment session is over for the day.
Please initial: YES ____________ NO ___________ Date: ____________________________

______________________________________ ____
Parent/Guardian Name (please print) Parent/Guardian Signature

Address: ____
Street Apt. City Zip Code

DOB: ___________________________ Last Tetanus Shot: _________________________________

Allergies to drugs or foods: ____

Special medications or pertinent info: ____

Telephone Numbers: Mother ____
Cell Home/Work
Father ____
Cell Home/Work

Family Physician: ____
Telephone

This authorization shall remain effective until this child is eighteen (18) years old or authorization is canceled in writing.

ALAMITOS PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS – 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 y our 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 y our 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: Your 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 form 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, not 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 services (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.

__________**(initial if received)** 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 right I may have regarding my protected health information.

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 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, representative, 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 Patient Name Birthdate

_______________________________ _______________________________

Patient 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

OPTIONAL