PATIENT INFORMATION

Name: _____
First Middle Initial Last
Date of Birth ___/___/___ Email: _____

Home: _____Work:_____Cell:_____

Address:_____City_____Zip Code_____

Marital Status: _____Single _____Married _____Divorced _____Widowed Sex: _____Male _____Female

Occupation: _____Driver's License # _____

Spouse or Guardian Name: _____ Emergency Phone # _____

Referring Doctor: _____

PAYMENT AGREEMENT:

I understand that payment for all physical therapy services is my responsibility regardless of insurance or other third party coverage.

Payment is due at the time service is rendered unless special arrangements are made. With the development of an account balance, a monthly statement will be sent to you. We accept payment by cash, check and credit card.

We will be happy to process your insurance claims and request assignment of private insurance benefits unless you pay in full at the time of treatment. It is your responsibility to understand your insurance policy and coverage. If special authorization is needed for physical therapy, it is your (the patient's) responsibility to obtain it from your insurance company.

CANCELLATION/NO SHOW:

If during the course of treatment, I must cancel a scheduled appointment, I will notify Cupertino Physical Therapy, Inc, no less than 24 hours before the time of the appointment. If I fail to give notice of cancellations, I understand that a $50 fee will be charged and I am responsible for payment of that fee, not my insurance company.

AUTHORIZATION FOR MEDICAL TREATMENTS AND FINANCIAL AGREEMENT:

I authorize medical payment directly to Cupertino Physical Therapy, Inc. I/We do hereby consent to and authorize the performance of all treatments, by the physical therapist and staff which they may deem advisable and agree to pay all charge incurred by reason thereof. I also hereby authorize release of information requested by my insurance company and/or its representatives. I fully understand that this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Guardian Date

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of Your Protected Health Information

Your protected health information will be used by Cupertino Physical Therapy, Inc or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Cupertino Physical Therapy, Inc may or may not agree to restrict the use or disclosure of your protected health information.

If Cupertino Physical Therapy, Inc agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke the consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Cupertino Physical Therapy, Inc reserves the right to modify the privacy practices outlined in the notice.

Signature:

I have reviewed this consent form and give my permission to Cupertino Physical Therapy, Inc to use and disclosure my health information in accordance with it.

Name of Patient (Print)

Signature_____ Date_____

PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

GENDER: M/F AGE: What are we seeing you for?

SMOKER: Y/N Please circle: LEFT/RIGHT

PREGNANT: Y/N Neck, Shoulder, Elbow, Hand

OCCUPATION: Mid-back, Low back

SPORT ACTIVITIES/HOBBIES: Hip, Knee, Ankle, Foot, Other

PAST MEDICAL HISTORY: Please circle each condition that you currently have or have had in the past:

Fracture	Diabetes	Cancer	High Blood Pressure
Sprain/strain	Osteoarthritis	Osteoporosis	Stroke
Trauma	Rheumatoid Arthritis	Heart diseases	Allergies/Asthma

Have you had a recent illness? (If yes, please explain: _____

Do you take anti-inflammatory medication? Y/N Do you take pain medication? Y/N

Other medications or supplements: _____

CURRENT MEDICAL HISTORY: Please circle each symptom that you are experiencing:

Numbness/tingling	Poor balance (Fall)	Nausea/Vomit/Dizziness	Soreness/Ache
Increased pain at night	Shortness of breath	Difficult walking/running	Stiffness/Pain
Weakness	Headaches	Decreased movement	

Other:

What date (approximately) did your current pain start? _____

How did it start? (Gradually/ suddenly /from injury): _____

My symptoms are currently (circle one): Getting better/ About the same/ Getting worse

What treatments have you received for this problem so far? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an X-ray, MRI, or other imaging study for this problem? Y/N

On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

What are your personal goals for therapy at this time? _____

CUPERTINO PHYSICAL THERAPY, INC

Credit Card Authorization Form

I_____, hereby authorize Cupertino Therapy, Inc. to charge my credit card.

This card will not be charged until patient responsibility amounts are determined by your insurance, according to the explanation of benefits. These amounts may include deductible and co-insurance. Copay amounts are still collected on the date of the visit as well as any late cancellations of failed appointments.

Patient Name:_____

Name on the card: _____

(if different from the patient's Name)

Credit Card Number: _____

Expiration Date: _____

CVC Code: _____

Credit card Billing Zip code: _____

Cupertino Physical Therapy Inc. will keep all information entered on this form secure and strictly confidential.

_____ _____

Cardholder's Signature Date

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