EAST COUNTY WATER & SPORTS PHYSICAL THERAPY

PATIENT INFORMATION			RR:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
How did you hear about us? _____			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City	State:	Zip:
Claim #:	Date of Injury: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to East County Water & Sports Physical Therapy. I understand that I am financially responsible for any balance. I also authorize East County Water & Sports Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

EAST COUNTY WATER & SPORTS PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
Vertigo/Dizziness	☐	☐
Tumor/Cancer	☐	☐

If you are in remission, how long? _____

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week? _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date: _____

Have you had any Auto Accidents? ☐ YES ☐ NO If yes list body part and date: _____

Police Report Files? ☐ YES ☐ NO Cost of Damage: _____

Have you seen a Chiropractor, Physical Therapist or Massage Therapist before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

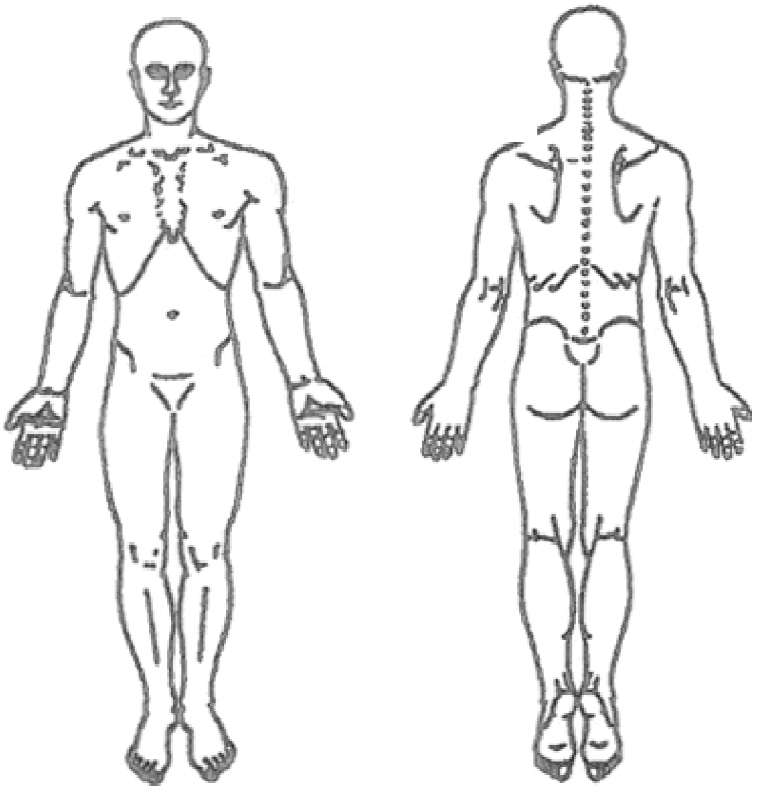
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

Addional Complaints _____

_____

_____

_____

Functional limitations: _____

Conditions/activities that increase symptoms: _____

Conditions/activities that decrease symtoms: _____

Activities preferred at home: _____

Activities preferred at work: _____

Additional Comments _____

East County Water & Sports Physical Therapy

10225 Austin Dr. Ste. 106, Spring Valley, CA 91978
619-660-8895 (fax)619-660-8697

PATIENT INFORMATION AND CONSENT TO TREAT

As a patient at **East County Water & Sports Physical Therapy**, you will be asked to perform specific activities on land and in the water (i.e. swimming pool) in order to allow the physical therapist to evaluate your physical condition and implement a treatment program for you to carry out under the direct supervision of the therapist. These activities include assessing and exercising through range of motion, strengthening and overall conditioning for all body parts deemed necessary by your physical therapist. In addition, various modalities such as ultrasound, electrical stimulation, traction, manual therapy, massage and ice therapy maybe used to complete your treatment program. At no time are you expected to experience any increase in pain or discomfort from its current level; however, during the evaluation process it is sometimes necessary to reproduce symptoms to fully evaluate the nature of the injury. At no time will you be forced to perform any activity or use any modality that you not wish to participate in due to pain or discomfort. If you feel any increase in pain or discomfort you are to stop immediately and report your problem(s) to the therapist.

There are certain risks involved in physical therapy evaluation and treatment on land and in the water. Since you are exerting a muscular effort, it is always possible to over exert yourself and cause an aggravation to your existing injury, or to develop a new musculoskeletal injury such as joint strains, nerve irritation and muscular soreness. Other risks involved in physical therapy include possible skin irritations from the use of the above-stated modalities, cardiovascular complications such as rapid heart rate, shortness of breath, and dizziness during and after conditioning exercises. The most severe risks from conditioning exercises are cerebral vascular attack and cardiac arrest.

There are certain risks involved with utilizing a swimming pool and locker room with physical therapy. These possible risks include injuries resulting from slip and fall accidents, ear infection, and eye and skin irritation. The most severe possible risk from water physical therapy is drowning. You may wish to utilize ear plugs, goggles, and water shoes such as NIKE Aquasocks while in the water. A floatation belt or vest will be provided for you during your deep-water treatment sessions.

For your personal safety, please do not get in the pool, adjust, or use any equipment (ie. stationary bike, treadmill, etc.) without the direct supervision of a staff member.

DECLARATION

I have been informed by Physical Therapist _____ of the nature, risks, possible methods of treatment, and possible consequences and complications involved in the evaluative and treatment methods of **East County Water & Sports Physical Therapy** for the relief of _____.

I have read and understand thoroughly the above information and am willing to participate in physical therapy with **East County Water & Sports Physical Therapy.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is under 18 yrs.)

Please initial:

_____ I have read and understand my patient rights.

_____ I have read and understand ECW&SPT statement of non-discrimination.

East County Water & Sports Physical Therapy

10225 Austin Dr., Ste. 106
Spring Valley, CA 91978
(619) 660-8895 (619) 660-8697 Fax

BILLING PROCEDURES

- As a courtesy to patients we will bill your insurance company directly upon your authorization
- If you choose not to assign insurance benefits to us, the full amount is due at the time of service
- Most insurance plans cover a percentage of physical therapy: the patient is responsible for the remaining percentage at the time of service.
- Please inform us if you have a deductible that has not been fully paid so we can work together on a suitable payment arrangement.
- The patient and/or spouse is fully responsible for payment of the account: any payments from the insurance carrier will be credited to the account.
- All accounts with an outstanding balance will receive a statement processed on the last business day of the calendar month.
- If you have difficulty paying after each visit, please let us know so we can work together on a suitable payment arrangement.
- As a courtesy to out patients, we call to verify what your insurance coverage will be. This is not, however, a guarantee of payment or coverage.
- All necessary equipment for land and water therapy will be provided at no cost to the patient during their scheduled physical therapy appointment. Any necessary equipment needed by the patient for a home exercise program will be required to be purchased by the patient. We offer this equipment at a discount. A receipt will be issued in order for the patient to bill their insurance company.
- As a courtesy to our patients, we file insurance claims with the primary insurance carrier. However, we cannot accept responsibility for collecting your insurance claims or for negotiating settlement on disputed claims.
- We accept cash or check drawn on a local bank. A $10.00 fee will be charged for returned checks.

INTEREST

All charges not paid in full within 30 days from the date they are rendered may be subject to a 2% interest charge each month (24% APR) on the unpaid balance. A $15 rebilling fee will be added to all accounts that are 90 days past due.

WE REQUIRE 24 HOUR CANCELLATION NOTICE

A THIRTY MINUTE TREATMENT CHARGE ($45-$55) WILL BE ASSESSED FOR NO SHOWS AND CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE

Insurance may or may not cover cancellation and no show fees. If you cancel less than 24 hours or no show this will count as a visit. **IF YOU NO SHOW FOR 2 VISITS, A LETTER OF NON-COMPLIANCE WILL BE SENT TO: 1) YOU, 2) THE REFERRING PHYSICIAN AND 3) YOUR INSURANCE CARRIER. YOU WILL BE REMOVED FROM THE SCHEDULE IF YOU NO SHOW FOR 2 APPOINTMENTS. IF NUMEROUS APPOINTMENTS ARE CANCELLED, YOU WILL BE PLACED ON HOLD UNTIL YOU CAN ATTEND REGULARLY.**

AUTHORIZATIONS

I hereby authorize the release of medical information to my insurance carrier, nurse case manager, or anyone else associated with my case that may be necessary to process my claims.

I hereby authorize payment directly to this practice for the medical expense otherwise payable to me.

I agree that if my insurance carrier does not pay for the services rendered unto me in full, I will be responsible to make full payment within 20 days of receipt of statement for services. This excludes pre-authorized worker's compensation claims.

In the event it is necessary to refer this account, I/we agree to pay all costs of collection including, but not limited to, reasonable attorney fees, court costs, and interest permitted by law.

I understand and acknowledge responsibility for all information explained to me in this document.

_____ _____

Patient signature **Date**

_____

Parent/Guardian (if under 18)

East County Water and Sports Physical Therapy

Patient Consent Form

East County Water and Sports Physical Therapy's Notice of Privacy Practices Policy informs you of how we may use or disclose your health information as mandated to us by the Health Insurance Portability and Accountability Act of 1996, effective April 2003. You have the right to a paper copy of the Notice of the Privacy Practices for your review before signing this consent. This information is considered "protected health information" under the HIPAA Privacy Rule. You have the right to request that we restrict how your "protected health information" is used and disclosed. We are not required to agree to your requested restriction. In signing this form, you consent to our use and disclosure of your "protected health information" for treatment, payment, and health care operations. You may revoke this consent in writing, except in such cases where we have already made disclosures in agreement of your prior consent.

This consent expires_____

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date