

Patient Name: _____

Today's Date: _____

Patient History Intake Form

1. Please describe the problem that brings you here, along with how and when it happened.

2. Please check whether this problem is Chronic (meaning persisting for a long time or constantly recurring) or Acute (meaning a rapid onset and occurred recently.)

3. Date of Injury: _____ Please be specific as possible. Approx. Time: _____

4. Date of Surgery, if any: _____

5. What makes the problem feel worse? _____

6. What makes the problem feel better? _____

7. What treatment have you had for this problem?
(X-Ray, MRI, Injections, Medications, acupuncture, chiropractic, etc.)

8. Date and location of last imaging test?

9. Current medications and supplements:

10. Does the discomfort disturb your work? Circle one: Yes/No If yes, please describe how: _____

11. Does the discomfort disturb your sleep? Circle one: Yes/No If yes, please describe how: _____

12. On a scale of 1-10 with 10 being the worst pain, please rate the pain level you have today /10

13. How would you describe the symptoms that you are experiencing? Circle all that apply

Numbness

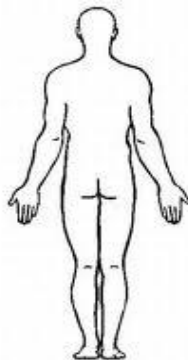
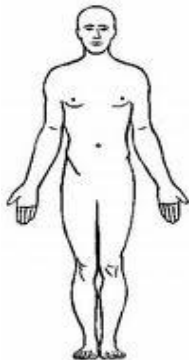
Pins & Needles

Burning

Stabbing

Aching

14. On the drawing below, please indicate the painful areas on your body that we will be treating by circling them



15. Do you have any of the following conditions? Circle all that apply

- High blood pressure
- Heart problems
- Vascular problems
- Back problems
- Kidney problems
- COPD
- Previous accidents
- Diabetes
- Stroke

- Cancer
- Seizures
- Metal implants
- Osteoporosis
- Anxiety
- Depression
- Chronic headaches
- Neurological disease
- Arthritis
- Allergies/Asthma
- Allergies to heat or ice

16. Are you currently or could you be pregnant? Yes/No

17. Please describe your occupation and activities at home:

18. Is there anything else you would like your physical therapist to know about?

19. Do you have an attorney representing you in a personal injury or workers compensation case? Y/N

If so, please provide contact information here:

20. Is there a person whom you would like to have access to information about your treatment, appointment dates and times or to communicate with our office on your behalf? Yes/No (circle one)

Name: _____ Phone: _____

Please list exactly what information may be shared with this person: (if it is not listed below-it will not be shared)

21. I have received a copy of the "Notice of Privacy Practices" _____(initial)

Patient Demographic Information

Name: _____ DOB: _____ Age: _____

Social Security Number: _____ - _____ - _____ (Required for Workers comp and blue cross/blue shield patients)

Email Address: _____
(Providing an email address will register you for our quarterly newsletter and provide another means of contact)

Driver's License Number: _____ Issue State: _____

Home Address: _____

Home Phone: () - Cell Phone: () -

Insurance Subscriber information: (If you, the patient, are the subscriber please put "self")

Name: _____ Date of Birth: _____

Subscriber relationship to patient: Spouse/Child/Other: _____

Referring Doctor Name: _____

Employer (required): _____

Employer Address: _____

Occupation (required): _____ Work Number _____

An emergency contact is required below: This person will be contacted in the event that we cannot reach you or there is an emergency during an office visit:

Emergency Contact Name: _____

Phone Number: () - Relationship: _____

I hereby authorize my insurance carrier to directly pay Bay Physical Therapy for all professional and medical services rendered to me. This is a direct assignment of my rights and benefits under my policy. I agree to pay in a timely manner and understand all copayments, coinsurances, and deductibles will be collected at the time of service. If I cancel within less than 24 hours or "no show" (Meaning do not call to cancel or come in to keep appointment) I fully understand I will be charged and required to pay a \$50.00 fee, payable before making any subsequent appointments. A photocopy of this shall be considered valid and effective. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in my case. I agree that regardless of my insurance status, I am responsible for any unpaid balance on my account for services rendered. I certify that this information is true and correct to the best of my knowledge. HIPAA

Signature Date

If under 18: _____
Guardian name and signature Date

Patient Guidelines

***Please read and initial each guideline**

Physical Therapists are highly educated, licensed health care providers who help patients improve or restore mobility and reduce pain. _____

We want you to receive the maximum benefits from your rehabilitation program. This means it is very important that you attend all of your therapy appointments, minimizing any absences or gaps and that you follow your home exercise program, if provided. _____

At your first appointment your physical therapist will perform a detailed evaluation and in most cases they will begin treatment. _____

You will get out of therapy what you put into it. Sufficient effort, as agreed upon between you and your therapist, is necessary to maximize the benefit from each treatment. _____

Cancellations require **24 business hours' notice** or you will be charged a \$50.00 missed appointment fee, *payable prior to your next appointment*. Unpaid missed appointment fees accrue interest and will be sent to collections. _____

No showing an appointment means that you do not call or you call right before a scheduled appointment to cancel. This is subject to the \$50.00 missed appointment fee. We reserve the right to discharge you from our care if there is more than one missed appointment _____

As a courtesy, our office offers appointment reminders via auto-phone call, text message or email. These reminders are sent from a third party and our office is not responsible for unreceived messages. It is your responsibility to keep track of scheduled appointments to avoid the missed appointment fee. _____

Please inform the front office staff of any upcoming medical doctor appointments so we may note it in your file. _____

Bay Physical Therapy and Sports Rehabilitation Center, Inc. dba
Bay Physical Therapy and Fitness Center
Shelley A. Kroopf, P.T. and Associates
500 Lighthouse Ave Ste B, Monterey CA 93940
Ph 831-375-5909 Fax 831-375-7259

As a courtesy, we will bill your primary and secondary insurance carriers. We do not bill tertiary. _____

We do our best to estimate your financial responsibility prior to treatment by contacting your insurance plan. The information provided to you is an estimate and we are not responsible for incorrect information. We *highly suggest* that you contact your insurance carrier and inquire about your benefits for physical therapy.

Our office collects copayments, coinsurance and deductibles at the time of service. The amount that we collect is considered an estimate until your insurance processes your visit and sends our office an explanation of benefits. _____

If we are not in-network with your insurance carrier, *benefits can be different and often can result in higher financial responsibilities*. It is the patient's responsibility to confirm network status. _____

Our office will make every effort to consistently schedule you with the same provider, however, there may be some days in which your therapist is unavailable and we may schedule you with another provider. _____

Our office does not permit spouses/friends or family to make changes to your appointment dates or times. We must speak directly to you. _____

I have read the above guidelines and I agree to adhere to them while I am being treated at Bay Physical Therapy. I understand that unpaid balances remaining on my account will accrue interest at 2% per month until paid in full.

Signature: _____ date: _____

Printed Name: _____

Bay Physical Therapy and Sports Rehabilitation Center, Inc. dba
Bay Physical Therapy and Fitness Center
Shelley A. Kroopf, P.T. and Associates
500 Lighthouse Ave Ste B, Monterey CA 93940
Ph 831-375-5909 Fax 831-375-7259

MEDICAL RELEASE FORM

Patient Name: _____ Date of Birth: _____

Ph: _____ Address: _____ City/State/Zip: _____

The above named patient authorizes the following healthcare facility to make record disclosure:

Facility Name

Facility Phone

Facility Fax

Type of information to disclose:

- 2 years prior from last date seen
- Specific date range: _____
- Specific information as follows:

Purpose of disclosure:

- Change of Insurance/DR
- Continuation of Care
- Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature: _____ DATE: _____