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

Patient Name: _____ Today's Date: _____

Patient History Intake Form

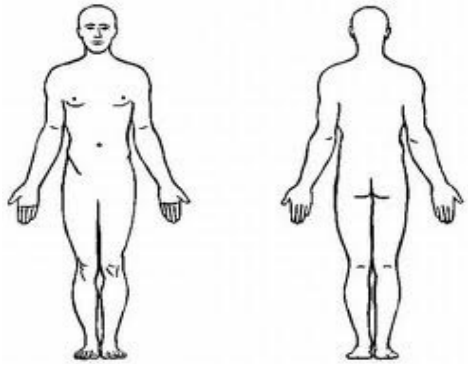
1. Please describe the problem that brings you here, along with how and when it happened.

_____
_____
_____
_____

2. Please check whether this problem is O Chronic (meaning persisting for a long time or constantly recurring) or
   O 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, ect.)
   _____
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 your currently or could you~~ be pregnant? Yes/No
17. Please describe your occupation and activities at home:

_____

_____

_____

Patient Guidelines

- In order to receive maximum benefit from your rehabilitation program, you must attend your therapy appointments and follow your home program.
- Cancellations within less than a full 24 hour notice are subject to a $50.00 fee X_____ (initial)
- Attention: Patients with workers compensation cases- If you cancel within less than 24 hour notice or no show an appointment, we will contact your Doctor's office and adjuster to make them aware and you will be responsible for the $50 no show fee.
- No Showing an appointment means that you do not call or you call right before a scheduled appointment to cancel.
- It is your responsibility to inform our staff of any Physicians appointments
- You are subject to being discharged from our practice after 3 missed appointments.
- We do bill your primary and secondary insurances as a courtesy. We do NOT bill tertiary. If you have a secondary insurance, there still may be a financial responsibility due at the time of your visit.
- We do collect copayments, coinsurances and deductibles AT the time of visit.
- Please note, **that as a courtesy**, we do verify your eligibility and benefits prior to your first appointment. However, this is an estimate and not a guarantee of coverage or payment. We strongly suggest that you call and confirm your coverage, eligibility, network status and financial responsibility prior to your first appointment. Should you rely on the information that is quoted to our office, and for some reason, the claims process differently, our office is not responsible. By signing below, you agree to pay any balance remaining, even if your insurance does not cover treatment for any reason.
- If we are not "in-network" with your insurance carrier, benefits can be different. It is your responsibility to verify this with your insurance company prior to your appointment.
- Our office offers email reminder calls and statements via email. Should you opt out of receiving a statement via email, an additional $1 per statement mailed per month will be added to your statement

I have read and agree with the above stated patient guidelines. I understand that unpaid balances remaining on my account will accrue interest at 5% per month until paid in full.

_____ _____

Signature Date

Patient Demographic Information

Name: _____ DOB: _____ Age: _____

Social Security Number: _____-_____-_____

Email Address: _____

Do you have an attorney representing you in a personal injury or workers compensation case? Y/N
If so, please provide contact information here:

_____

_____

Driver's License Number: _____ Issue State: _____

Home Address: _____City/State/Zip: _____

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

Referring Doctor Name: _____ Phone #_____

Employer: _____

Employer Address: _____

Occupation: _____ Work Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Insurance Subscriber information:

Name: _____ Date of Birth: _____

Subscriber relationship to patient: _____

Workers Compensation Adjuster Name:_____ Phone Number: _____

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. By signing below, I agree that regardless of my insurance status, I am responsible for any unpaid balance on my account for services rendered and I understand my account will accrue interest at 5% per month. I certify that this information is true and correct to the best of my knowledge.

_____ _____
Signature Date

If under 18: _____ _____
Guardian name and signature Date