Physical Therapy Dynamics & Sports Medicine
Patient Information Form

MR.□ MRS.□ MS.□	
Name:	Spouse Name:
Parent Name(If minor):	
Home Phone #:	Work Phone #:
Address -Number & Street Name:	City, State & Zip Code
Employer:	Occupation:
Social Security #:	Date of Birth:
Spouse/Parent Employer:	Phone #:
Address -Number & Street Name:	City, State & Zip Code:
Spouse/Parent SS#:	Spouse/Parent DOB:
Date of Injury:	
Is this a work related injury? Yes□ No□	
Do you have a lawyer representing you? Yes□ No□	
Please list name of lawyer:	Phone #:
Who is your primary physician?	
Did the physician who issued the prescription for Physical Therapy refer you to our facility for treatment? Yes□ No□ If the answer is No, please list who referred you to our facility.	
How did you hear about our facility?	
When is your next scheduled appointment with the referring physician?	
List two emergency contacts (nearest relative or friend): Name:_____Relationship:_____Phone#_____ Name:_____Relationship:_____Phone#_____	

Physical Therapy DYNAMICS

Specializing in Orthopaedic & Sport Rehabilitation, Spinal & Geriatric Injuries

Patient Consent Form

By signing this form, you are granting consent to Physical Therapy Dynamics & Sports Medicine to use and disclose your protected health information, when it is appropriate and necessary, for the purpose of treatment, payment, and health care operations. When doing so, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide your best interest. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change from time to time without notice. If we change our Notice, you may obtain a copy of the revised Notice by contacting our organization at (818) 348-0580 or by accessing our website at www.ptdynamics.net.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations but this must be done in writing. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to this or the extent we already have used or disclosed your protected health information in reliance on a prior signed consent.

_____ _____

Signature Date

History of Present Condition

1. What are your symptoms?

2. When did your symptoms begin?

3. Was the **onset** of this episode gradual or sudden?

4. Which of the following **best describes** how your injury occurred? (check all that apply)

□ lifting	□ trauma	□ hit by a ball
□ MVA (car accident)	□ degenerative process	□ dental appointment
□ a fall	□ during recreation/sports	□ throwing
□ cumulative trauma	□ running	□ unknown
□ overuse	□ blow to the face	□ list other below

5. Since onset, are your symptoms getting:

□ Better	□ Worse	□ No change

6. Have you had similar symptoms in the past?

□ Yes	□ No

7. Nature of pain/symptoms (check all that apply)

□ Sharp	□ Throbbing	□ Periodic	□ Constant
□ Dull	□ Aching	□ Occasional	□ List other below

8. As the **day** progresses, do your symptoms:

□ Increase	□ Decrease	□ Stay the same

9. Does the pain wake you at night?

□ Yes	□ No

10. Do you have pain/stiffness upon getting out of bed in the morning?

□ Yes	□ No

11. In what position do you sleep?

□ Right side	□ Stomach	□ Chair/recliner	□ List other below
□ Left side	□ Back	□ Back, side, stomach	

12. Other Medical Symptoms? (check all that apply)

□ Bowel/Bladder difficulty	□ Dizziness/Fainting attacks	□ Malaise
□ Fever/Chills	□ Weakness	□ Vision/Hearing problems
□ Genital/Anal numbness	□ Weight gain	□ None noted
□ Numbness	□ Night pain/Sweats	□ List other below

13. What aggravates your symptoms? (check all that apply)

□ Sitting	□ Reaching	□ Coughing/sneezing
□ Going to/rising from sitting	□ Standing	□ Taking a deep breath
□ Lying down	□ Squatting	□ Looking up overhead
□ Walking	□ Sleeping	□ Swallowing
□ Going up/down stairs	□ Household activities	□ Stress
□ Recreation/sport: please specify		
□ Repetitive activities/motion		
□ Oral activities: please specify		
□ List other:		

14. What relieves your symptoms? (check all that apply)

□ Sitting	□ Rest	□ Massage
□ Heat	□ Standing	□ Medication
□ Cold	□ Walking	□ Nothing
□ Stretching	□ Exercise	□ List other below
□ Wearing splint/orthosis	□ Lying down	

15. Have you had any previous treatment for this condition? (check all that apply)

□ None	□ Bracing/taping	□ TENS unit
□ Medication (oral)	□ Injection into the spine	□ Acupuncture
□ Joint manipulation DC/DO	□ Injection into the skin/muscle	□ Bed Rest
□ Exercise	□ Physical Therapy	□ Overnight hospitalization
□ Massage therapy	□ Hypnosis	□ Casting
□ Traction	□ Biofeedback	□ List other below

16. Have you had any of the following tests? (check all that apply)

□ None	□ MRI	□ Bone Scan	□ Vestibular
□ X rays	□ Arthrogram	□ NCS	□ List other below
□ CT scan	□ Stress X ray test	□ Fluroscope	□

Medication

Are you currently taking any medication for your condition?

□ Prescription: please specify
□ Non-prescription: please specify
□ None
□ List other:

Insurance Information Form

Health and accident policies are an arrangement between you and your insurance company. Notwithstanding any such arrangement, you are personally financially responsible for all services rendered in our office. All unpaid charges will be billed directly to you, the patient. We accept assignment of benefits after your insurance coverage has been verified. Your insurance company will send payment directly to our office. We will promptly credit all received payments from your insurance company. Any balance remaining unpaid after payment by any insurance company will remain your responsibility to pay.

Patient name (PRINT):_____Insurance Company:_____

DEDUCTIBLE:$_____(per year)
In order to meet your calendar year deductible we require that you, the patient, pay $180.00(one-hundred eighty dollars) per visit, prior to treatment until your deductible is met, also $180.00 is our per visit cash price.

COPAYMENT:$_____(per visit). The patient is responsible for the estimated percentage before treatment is rendered.

Have you had any physical therapy visits with any physical therapist within this year? YES □ _____(number of visits) NO □

Have you had any chiropractor, acupuncture, speech therapy, or occupational therapy visits any time this year?
YES □ _____(number of visits) NO □

Our office will not enter into a dispute between you and your insurance company over claims. This is your responsibility and obligation. _____ (**Patient's initials)**.

You acknowledge and agree that you or your legal representative will be financially responsible for, and pay promptly when billed, all charges for any services rendered to you by us that may ultimately be determined by your insurer to be not covered services, not authorized, or not medically necessary._____ (**Patient's initials).**

If you receive any checks from your insurance carrier, you are responsible to sign the check on the back and turn it in to our office within 5 business days._____ (**Patient's initials).**

ADDITIONAL CHARGES

Return check charge:	$25.00 per check
Cancellation charge:	$25.00 for a NO-SHOW appointment or a cancellation that is not given within a 24-hour notice (or by 2 p.m. on a Friday afternoon for an appointment the following Monday). We require a credit card on file that we are allowed to charge if patient does not show up at appointment or call before required 24 hour period _____(**Patient's initials).**
Late payment charge:	$10.00 or 1.5%(whichever is greater) will be added to your account along with a collection service and/or attorney fees for delinquent accounts. There will be a $15.00 office charge for the copying of medical records.

PRIVATE & MEDICAL INSURANCE—The fees charged in our office are comparable to those charged by other physical therapists in this area with similar qualifications.

WORKER'S COMPENSATION—If you are hurt on the job, your employer's workers compensation insurance will pay 100% of your care, upon authorization from the adjuster.

PERSONAL INJURY/AUTO ACCIDENT—If you have Med-pay coverage on your automobile policy we will bill them for prompt and direct payment. Med-pay will cover your doctor bills regardless of who was at fault. If there is no Med-pay coverage we will bill your health insurance and any balance will be billed to you upon completion of services.

My signature below states that I have read the above, and have been informed of my insurance benefits, as stated by my insurance company. I am aware of my financial responsibility to Physical Therapy Dynamics. I understand and agree to the above terms and conditions. I agree that a photostatic or facsimile copy of this document is as valid as the original.

Patient Signature:_____ Date:_____