COASTherapy

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone ( ) - _____ Work Phone ( ) - _____ Cell Phone ( ) - _____

Date of Birth _____ Gender _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone ( ) - _____

Employer

Name _____ Phone ( ) - _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

That occurred in: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I, the undersigned, do hereby agree and give my consent for Empower Physical Therapy to furnish medical care and treatment to the patient named above considered necessary and proper in diagnosing or treating his/her physical condition

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

I authorize release of information requested by my insurance plan for payment.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature:_____ Date:_____

Financial Policy/Agreement

Please call your insurance carrier so that you can better understand your benefits. Although our office does verify coverage, online services only provide limited information. While we try to obtain accurate insurance benefits, we are occasionally given incorrect information. **If this occurs, you are responsible for any difference between what was quoted by your insurance company and what was actually paid.** If your insurance company requires you to have a referral or authorization for physical therapy, please verify with our front office that a current referral or authorization is on file. Many plans require authorization numbers for physical therapy visits. Our office will put forth as much effort as possible to help obtain these documents, however, the **patient is ultimately responsible for any resulting costs that may be associated with your visits.** It is your responsibility to know which insurance is your primary carrier and which is your secondary. We rely on the information that you provide. Your signature below further verifies that you have not joined an HMO or other entity in which your Medicare/all other insurance benefits have been relinquished.

THE PATIENT IS ACCOUNTABLE FOR UNDERSTANDING THEIR INSURANCE BENEFITS, VERIFYING NECESSARY REFERRALS/AUTHORIZATIONS ARE ON FILE AND PAYING SUBSEQUENT OUT OF POCKET EXPENSES. COPAYS AND CO-INSURANCE PAYMENTS ARE DUE AT TIME OF SERVICE.

We have been informed that you have the following estimated responsibility:

Primary Insurance Carrier: _____ Copay (if applicable): _____

Prior Authorization Required _____ Authorization #: _____
Number of visits approved _____ Start Date _____ End Date _____

Annual Deductible	Amount Remaining	Avg Cost/Visit	Coinsurance %	Payment per visit after deductible is met

Secondary Insurance Carrier: _____ Copay (if applicable): _____

Annual Deductible	Amount Remaining	Avg Cost/Visit	Coinsurance %	Payment per visit after deductible is met

THE AMOUNT ABOVE IS BASED OFF AVERAGE MARKET COSTS PARTICULAR TO YOUR INSURANCE PLAN, THIS IS NOT AN EXACT AMOUNT. IF YOU HAVE A DEDUCTIBLE AND/OR A CO-INSURANCE PLAN, YOUR FINAL STATEMENT MAY REFLECT A **BALANCE** DUE OR A **CREDIT** AT THE END OF ALL SERVICES AFTER CLAIMS HAVE PROCESSED.

In the event of non-payment, your account will be turned over to collections. At this time, Thunderbird Collection Specialists (TCS), our collections company, will charge an additional 35% fee to the balance owed on your account. There is also a $25.00 charge for bounced checks.

By signing below, I agree to pay the amount written above at the time of service and I understand that I am responsible for any balance due after my treatment plan.

Patient Name: _____ Date: _____

Patient Signature: _____

Benefits Explained by (Empower PT Employee Signature): _____

Dear Patient,

We would like to take a moment to welcome you to our family. We strive for a healthy, active lifestyle for each and every one of our patients; we look forward to working with you. Before we start, we want to find the easiest and most convenient way to keep you informed about your appointments

Phone Number: _____ Cell Carrier: _____

E-Mail Address: _____

☐ E-Mail Reminders

☐ Text Message Reminders

HUNTINGTON BEACH
9036 Adams Ave ● Phone: 714-963-7712 ● Fax: 714-965-0682
Anaheim Hills
6200 E. Canyon Rim Road, Suite 113 ● Phone: 714-974-0330 ● Fax: 714-974-1434
Orange
1111 W. Town and Country● Phone: 714-997-5518 ● Fax: 949-313-1749

Website:
www.coastherapy.com

CONSENT TO TREATMENT MINOR

I ,begin the parent(s) of _____, do hereby consent, authorize and request COASTHERAPY to administer such treatment deemed advisable, necessary or requested.

I agree to hold COASTHERAPY, and any of its employees or agents, free and harmless from any complaints, suits for damages or complications which may result from such treatment.

Patient Signed: _____Date: _____

Parent/Guardian Signed: _____ Date: _____

Witness Signed: _____ Date: _____

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Cancelation Policy

There is a **$25.00** charge for any appointments that are cancelled with less than 24 hours advanced notice.

Signature: _____ **Date**: _____

HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature of Patient or Responsible Party: _____

Relationship to Patient: _____ **Date**:_____

COASTherapy
PHYSICAL THERAPY
SPORTS MEDICINE GROUP

NAME:_____

Age? _____ Today's Date:_____

Date of Injury/Surgery: _____

Dominant Arm? Right / Left

Height: _____ **Weight: _____**

Problem(s) (please check all that apply)

† □ Pain?

□ Weakness?

† □ Instability / Dislocation

† □ Stiffness?

† □ Swelling?

† Other_____

How did you injure yourself?

† □ No injury – just started hurting

† □ Sports (which sport?)_____

† □ Motor Vehicle Accident

† □ Work / Job

Is there a Worker's Comp Claim?

Yes / No

Sports Level:

none / recreational / college / professional

How long have you had symptoms?

____Days _____ Months _____Years

Please briefly describe the injury:

_____
_____

Diagnosis (if you have been told)?

_____

Medications (please List):

_____
_____
_____
_____

Have you experienced a fall in the Last Year? Please Explain:

_____
_____

Previous Treatments (other than surgery) (medications, physical therapy, injections, bracing)

_____
_____
_____

Previous surgery or Medical Conditions: (include dates)

_____
_____
_____

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations

_____
_____

Have you had any imaging studies?

X-rays No / Yes Date: _____

MRI No / Yes Date: _____

CT Scan No / Yes Date: _____

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PHYSICAL THERAPY
SPORTS MEDICINE GROUP

Allergies to medication(s)/Latex? _____

Do any diseases run in your family? _____

Medical History: (please circle)

Do / did you have heart problems? No / Yes

Do / did you have ulcers / gastritis? No / Yes

Do / did you have diabetes? No / Yes

Do / did you have liver issues, hepatitis No / Yes

Do / did you have kidney disease? No / Yes

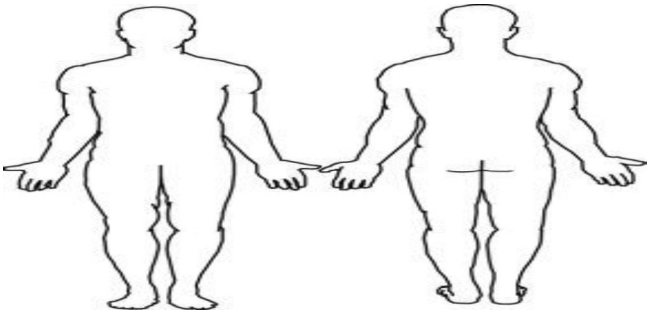
Do / did you have blood clots? No / Yes

Do / did you have cancer? No / Yes

Do / did you have HIV/Aids? No / Yes

Other? (Please use back of sheet if necessary)

Please circle area of discomfort on Body below:



RATE THE INTENSITY OF YOUR PAIN											
AT BEST	0	1	2	3	4	5	6	7	8	9	10
AT WORST	0	1	2	3	4	5	6	7	8	9	10
CONSTANTLY	0	1	2	3	4	5	6	7	8	9	10

On the scale below **CIRCLE** your pain level in the past couple of days:

How optimistic are you that you'll get better? (Please Circle One)

Not at all Mildly Optimistic Fairly Very Optimistic Extremely

Goals for PT: _____

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PATIENT MEDICAL HISTORY

Name: _____ Date: _____Date of injury or surgery: _____

Referring Physician: _____Family Physician: _____

Current Medications List: _____

Current Pain Level (circle) 1 2 3 4 5 6 7 8 9 10 Have you ever been to physical therapy before? YES NO

Have you had any of the following Medical or Rehabilitative Services for ***THIS INJURY/EPISODE?***

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other: _____

Do You Have or Have You Ever Had Any of the Following?

	YES	NO		YES	NO
Asthma, Bronchitis	___	___	Severe or frequent headaches	___	___
Angina	___	___	Emphysema	___	___
Shortness of breath/chest pain	___	___	Vision or hearing difficulties	___	___
Coronary Heart Disease	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight loss/Energy loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemo/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/ Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you currently pregnant?	___	___
Emotional/Psychological Dx	___	___	Do you use Tobacco?	___	___

Patient/Guardian Signature: _____ **Date**: _____