PATIENT INFORMATION

NAME	SEX	AGE	BIRTHDATE	MARITAL STATUS
ADDRESS	EMPLOYER NAME			☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED
CITY STATE ZIP	ADDRESS			
PHONE Please check the number you prefer to be called at: ☐ HOME ( ) ______ ☐ CELL ( ) ______ ☐ WORK ( ) ______	CITY STATE ZIP REFERRED BY: ☐ MD ______ ☐ Friend ______ ☐ Other: ______			
DRIVERS LICENSE NO	E-MAIL			
NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU	ADDRESS	CITY	STATE	ZIP

SPOUSE / PARENTS INFORMATION or RESPONSIBLE PARTY

NAME	RELATION TO PATIENT	OCCUPATION
ADDRESS		EMPLOYER
CITY STATE ZIP		ADDRESS
HOME PHONE ( )		CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
NAME OF INSURED		ADDRESS	
POLICY HOLDER (COMPANY NAME IF GROUP)	GROUP NO.	POLICY HOLDER (CO. NAME IF GROUP)	GROUP NO.
POLICY OR CERTIFICATE NO.	EFFECTIVE DATE	POLICY OR CERTIFICATE NO.	EFFECTIVE DATE
PATIENT IS: OTHER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ SPECIFY ______		PATIENT IS: OTHER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ SPECIFY ______	

WORKERS COMPENSATION or ACCIDENT INFORMATION

INDUSTRIAL ☐ YES ☐ NO	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	INDUSTRIAL CLAIM NO.
NAME OF INSURANCE CARRIER			
PHONE ( )	FAX ( )	CLAIMS ADJUSTER	PHONE ( )
ACCIDENT ☐ YES ☐ NO	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY PHONE ( )

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render our services on the basis that insurance companies are financially responsible.

CONSENT FOR TREATMENT

I hereby authorize my consent to be treated now and in the future by England Physical Therapy.

INSURANCE AUTHORIZATION AND ASSISGNMENT

I hereby authorize England Physical Therapy to furnish information concerning my illness and treatment to insurance carriers and I hereby authorize my insurance company to pay by check made out and mailed direct to:

England Physical Therapy
12465 Lewis Street, Suite 101 ● Garden Grove, CA 92840 ● Phone (714) 703-8477 ● Fax (714) 703-8157

NOTE: A photocopy of this is considered as valid as the original.

PATIENT SIGNATURE______________________ INSURED SIGNATURE______________________

DATE: ______/______/______

ENGLAND PHYSICAL THERAPY
12465 Lewis Street ● Suite 101 ● Garden Grove, CA 92840
Phone (714) 703-8477 ● Fax (714) 703-8157

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, ______________________, understand that as part of my health care, England Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of the Privacy Act* that provides a description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that England Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that England Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should England Physical Therapy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

X______________________________________ **X**______________________

Patient's Signature **Date**

FOR OFFICE USE ONLY

[ ] Consent received by ________________________________ on ______________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on __________________________.

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

CHECK YOUR AUTHORIZED AND PREFERRED CONTACT METHODS (check all that apply)**:**

Okay to use this method	Preferred method	Contact Method	Comments
☐	☐	Home Phone: ( ) __ __ __- __ __ __ __	
☐	☐	Cell Phone: ( ) __ __ __- __ __ __ __	
☐	☐	Work Phone: ( ) __ __ __- __ __ __ __	
☐	☐	Fax Number: ( ) __ __ __- __ __ __ __	
☐	☐	E-mail: ____________________@_______________	
☐	☐	Other:	

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

X____ X____________________________

Patient / Guardian Signature **Date**

FOR OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosure to Whom	Authorized (yes/no)	Description of Disclosure*	Purpose of Disclosure	Disclosed By	Method Sent**

*Description Key: **T**=Treatment Records; **P**=Payment Information**;** **O**=Healthcare Operations
Enter how disclosure was made: **F=Fax**;** **P**=Phone; **E**=Email; **M**-Mail; **O**=Other

Welcome to England Physical Therapy

It is our goal to provide you with the highest quality of care in the most effective and compassionate manner possible. Your understanding of the office procedures will enhance our efforts on your behalf. To assist you, we have prepared the following material as an introduction.

Policies

Regarding Referrals to Physical Therapy

Most insurances require a physician referral for reimbursement of physical therapy services. Please bring your physician referral to your first appointment. In order to prevent an interruption in your care, we ask your cooperation in maintaining a current physical therapy referral from your physician. It is your responsibility to obtain current physician referrals as needed during the course of your treatment. Medicare requires an updated Plan of Care (POC) every 30 days. The physical therapist will send a written POC to your physician for certification.

Your Appointment is Important to Us

For your convenience, our hours are 7:30 a.m. to 6:00 p.m. To aid us in accommodating your scheduling needs, it is helpful to schedule your appointments a week in advance. It is your responsibility to make and keep your appointments. In fairness to our other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late.

We realize that sometimes you may need to cancel or reschedule an appointment. Since we reserve an individual time for you on the schedule, we ask that you cancel any of your scheduled appointments at least 24 business hours in advance. Failure to do so will result in a late cancellation fee ($50.00) or “No Show” fee ($100.00). Your insurance company will not pay for a late cancellation or “No Show” fee; it will be payable by you upon your next visit.

Our Financial Policy

In the spirit of cooperation, we are always happy to discuss fully and openly our fees and payment policy. We appreciate your choosing England Physical Therapy and will work with you in making arrangements that are mutually satisfactory. Please note the following regarding our financial policy:

Charges

- If you do not have health insurance, or if England Physical Therapy is not contracted with your insurance plan, you will be required to pay at the time of service.
- It is your responsibility to provide us with complete, accurate and up-to-date information in order for us to successfully bill your insurance company.
- It is your responsibility to take care of applicable deductibles, co-payments, co-insurances and outstanding balances at the time of service.
- If your plan requires prior authorization from your primary care physician, authorization must be obtained prior to your visit to England Physical Therapy.
- Interest will be added to your account 30 days after the first bill goes out (1.5% per month).
- We stock some supplies for your convenience. Supplies issued are payable at the time they are vendored to you (excluding Worker’s Comp). We will provide you with a receipt so you may submit for reimbursement from your insurance carrier.

Insurance

- We will need to copy your insurance card(s), a photo ID and have you complete a form including consent for treatment and assignment of benefits for billing purposes.
- As credentialed providers for Medicare, we bill Medicare and any applicable secondary insurance.

Your insurance policy is a contract between your insurance company and you. As a courtesy, we bill your insurance company. If for any reason your health insurance plan does not pay for service rendered, you are responsible for all charges.

I have read and understand the above policies.

____ ________________________

Patient Signature Date

ENGLAND PHYSICAL THERAPY
GENERAL PATIENT HISTORY QUESTIONNAIRE

☐ Dr.
☐ Mr.
☐ Mrs.
☐ Miss
☐ Ms.

NAME: ___________________________ **AGE:** _____ **BIRTHDATE:** ____/____/____ **HEIGHT:** _______
Occupation: _______________________ **Hobbies/Interests:** ____
If children, ages? __________________ ____

List in order the problem(s) you are here for:

Problem	When did the problem start?
1.	
2.	
3.	

Please list your GOALS in coming to physical therapy. *Think about things you would either like to be able to do, or things you would like to be able to do better.*

1) ____
2) ____
3) ____

List any TREATMENT(s) you have had for your current problem: *(prior PT, psychologist, chiropractor, acupuncture)*

____

Please list all SURGERIES and dates: *(continue on back of page if necessary)*

Surgery	Date

Please list all SERIOUS ILLNESSES and dates: *(continue on back of page if necessary)*

Illness	Date

SYSTEMS REVIEW

☐ Heart trouble	☐ Thyroid Disease	☐ Kidney stones	☐ Eye problems
☐ High blood pressure	☐ Stroke / Paralysis	☐ Gout	☐ Ear problems
☐ Asthma	☐ Migraine	☐ Arthritis	☐ Blood transfusion
☐ Emphysema	☐ Epilepsy	☐ Blood clots	☐ Mental illness (type):
☐ TB	☐ Meningitis	☐ Elevated cholesterol	☐ Venereal disease
☐ Pneumonia	☐ Hepatitis	☐ Ulcer	☐ Cancer (type):
☐ Pleurisy	☐ Liver disease	☐ Colitis	☐ Tropical disease
☐ Other lung disease	☐ Gallstone	☐ Bone disease	☐ Allergies:
☐ Diabetes	☐ Kidney disease	☐ Back problems	
GENERAL	**MOUTH**	**STOMACH & INTESTINES**	**SKIN**
☐ Recent wt. gain:_____	☐ Sore tongue	☐ Nausea	☐ Easy bruising
☐ Recent wt. loss:____	☐ Bleeding gums	☐ Vomiting	☐ Redness
☐ Fatigue ☐ Weakness	☐ Sores in mouth	☐ Stomach pain relieved by food or milk	☐ Rash Where: ____________
☐ Fever	☐ Loss of taste	☐ Yellow jaundice	☐ Hives
NERVOUS SYSTEM	☐ Dryness	☐ Constipation	☐ Tightness
☐ Headaches	**THROAT**	☐ Persistent diarrhea	☐ Hair loss

☐ Dizziness	☐ Freq. Sore throats	☐ Blood in stools	☐ Nodules/bumps
☐ Fainting	☐ Hoarseness	☐ Heartburn	☐ Color changes of hands or feet in the cold
☐ Muscle spasm	☐ Difficulty swallowing	**KIDNEY/URINE/BLADDER**	**MUSCLES/JOINTS/BONES**
☐ Loss of consciousness	**NECK**	☐ Incontinence	☐ Morning stiffness ___minutes ___hours
☐ Sensitivity/pain of hands/feet	☐ Swollen glands	☐ Difficult urination	☐ Joint pain Where:________________
☐ Memory loss	☐ Tender glands	☐ Pain burning w/ urination	☐ Muscle weakness
☐ Paralysis	**HEART & LUNGS**	☐ Blood in urine	☐ Muscle tenderness
EARS	☐ Pain in chest	☐ Cloudy "smoky" urine	☐ Joint swelling
☐ Ringing in ears	☐ Irregular heart beat	☐ Pus in urine	**NOSE**
☐ Loss of hearing	☐ Sudden change in heart beat	☐ Frequent urination	☐ Nosebleeds
EYES	☐ Shortness of breath	☐ Getting up at night to pass urine	☐ Loss of smell
☐ Pain	☐ Difficulty breathing at night	☐ Discharge from penis/vagina	☐ Dryness
☐ Redness	☐ Swollen legs or feet	☐ Vaginal dryness	
☐ Loss of vision	☐ High blood pressure: __________	☐ Sexual difficulties	**SMOKING** ☐ No ☐ Yes ______packs/day
☐ Double or blurred vision	☐ Heart murmurs	☐ Prostate trouble	**EXERCISE:** ☐ Walk ☐ Run ☐ Yoga
☐ Dryness	☐ Cough	**BLOOD**	☐ Swim ☐ Bike ☐ Hike
☐ Glaucoma	☐ Coughing of blood	☐ Anemia	**ALCOHOL** ☐ None ☐ Light ☐ Medium ☐ Heavy
☐ Cataracts	☐ Wheezing	☐ Bleeding tendency	
	☐ Night sweats		

CURRENT MEDICATIONS: ☐ *See attached list*

Medication	Dose	How Often

PHYSICIAN INFORMATION: *List **all** doctors you would like to receive a copy of your physical therapy evaluation.*

Neurologist/ENT/Cardiologist/Gerontologist/Osteopath	**Address/Phone/Fax**	**Specialty**
Referring MD:		
Primary Care MD:		

I certify that the foregoing statements are true to the best of my knowledge and belief.

_______________________________ _______________________________

Signature of Patient Date

_______________________________ _______________________________

Reviewed by Physical Therapist Date