Fresno Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

***Fresno Physical Therapy*'s LEGAL DUTY**

Fresno Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Fresno Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Fresno Physical Therapy*** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Fresno Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ***Fresno Physical Therapy's*** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Fresno Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***Fresno Physical Therapy*** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Fresno Physical Therapy*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***Fresno Physical Therapy's*** health information practices or if you have a complaint, please contact the following person:

Fresno Physical Therapy
Office Administrator-Chris Mason
4005 N. Fresno Street, Suite 106, Fresno, CA 93726 Telephone: (559) 227-4440 Fax: (559) 227-4443

FRESNO PHYSICAL THERAPY

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____BIRTHDATE_____

AGE_____ SSN_____-_____-_____ SEX: M F MARITAL STATUS: M / S / W / D

HOME PHONE _____CELL PHONE_____WORK PHONE_____

EMPLOYER _____ JOB TITLE _____

ADDRESS_____ SUPERVISOR _____

CITY _____ STATE_____ZIP_____

EMERGENCY CONTACT _____ PHONE _____

IF PATIENT IS NOT THE RESPONSIBLE PARTY
GUARANTOR:_____ / SPOUSE / PARENT

SOCIAL SECURITY NUMBER_____-_____-_____ DOB _____

EMPLOYER _____ JOB TITLE _____

ADDRESS_____ SUPERVISOR _____

CITY _____ STATE_____ZIP_____

INSURANCE NAME_____ ID/CLAIM # _____

ADDRESS_____ PHONE _____

CITY_____ STATE_____ZIP_____ ADJUSTOR/CONTACT_____

REFERRING PHYSICIAN_____PHONE_____

INJURED AT WORK? Y N MOTOR VEHICLE ACCIDENT? Y N DATE OF INJURY_____

ATTORNEY NAME _____CONTACT PERSON _____

ADDRESS_____ PHONE _____

CITY_____ STATE_____ZIP_____

This office will bill all contracted payers. **Patient copayments are due at time of visit.** Payment arrangements can be made for large deductibles. I authorize the release of any medical information necessary to process my claims. **I authorize payment of medical benefits to Fresno Physical Therapy** for services rendered.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible after 60 days for all charges whether or not paid by said insurance company. I hereby authorize said insurance company to release any information necessary to secure payment.

PATIENT / GUARDIAN _____ DATE _____

FRESNO PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

NAME_____DATE_____

Are you presently working? Y N Date of next physician's visit_____

Date of injury/ onset_____ Have you experienced these symptoms before? Y N

Have you had a related surgery? Y N If Yes, please give date_____

If female, are you pregnant? Y N

Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Hypoglycemia	☐	☐
Chest Pain/Angina	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Osteoporosis	☐	☐
Heart Disease	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Dizziness/Fainting	☐	☐
Headaches	☐	☐	Fractures	☐	☐
Kidney Problems	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Stroke	☐	☐	Nausea/Vomiting	☐	☐
Bowel/Bladder Abnormality	☐	☐	Ringing in your ears	☐	☐
Urine Leakage	☐	☐	Rheumatic Arthritis	☐	☐
Asthma/Breathing Difficulty	☐	☐	Smoking	☐	☐
Liver/Gallbladder Problems	☐	☐	Other	☐	☐

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

_____

_____

Do you have any allergies? Y N If yes, please list_____

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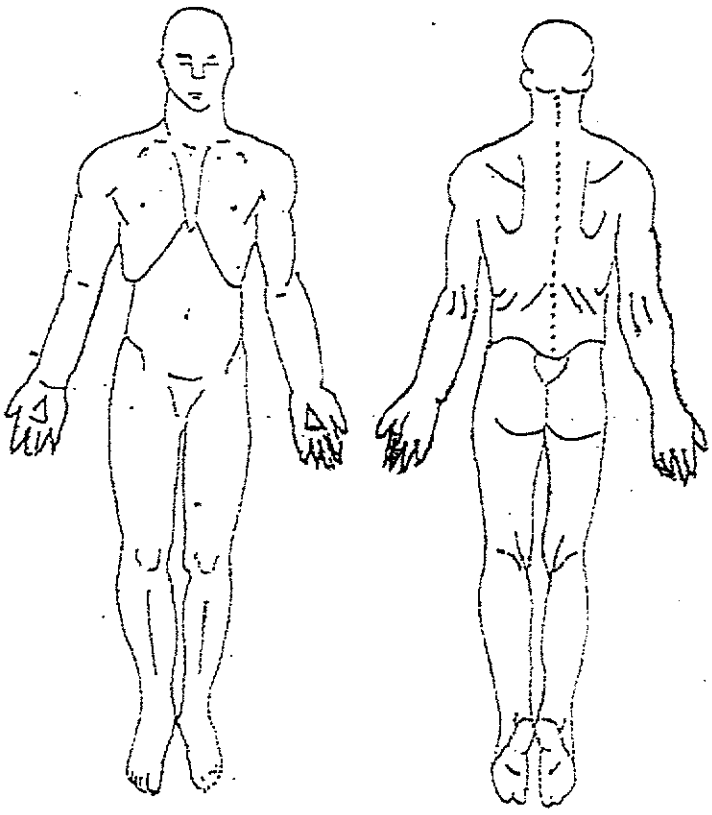
Are you presently taking any medication? Y N If yes, please list what medication and for what condition _____

_____

Do you participate in any sports, exercise program or activities on a regular basis? Y N

Please indicate below where your symptoms are located:



KEY	
Numbness	═══
Pins and Needles	00000000
Burning Pain	XXXXX
Stabbing Pain	//////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible _____

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Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Fresno Physical Therapy. My treatment plan will be explained to me by the treating therapist and I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature_____ Date_____

Signature of Parent/Guardian_____ Date_____

FRESNO PHYSICAL THERAPY

4005 N Fresno St., #106
Fresno, CA 93726
PH (559) 227-4440 FAX (559) 227-4443

Chris Mason, P.T.
Jeff Lawson, P.T.

CANCELLATION AND NO-SHOW POLICY

Fresno Physical Therapy will schedule a specific appointment time with you in order to offer individual services for your rehabilitation. After your first appointment you will be given an appointment card with your designated time for physical therapy. Please be sure to refer this card when making other outstanding appointments so you do not schedule yourself in two places at once.

We understand that occasional unavoidable circumstances arise in your life. If you must change your appointment time, please be considerate of our time by giving 24-hour notice. This form will serve as your notice for charges of $35 billed to you if you fail to keep your appointment without giving us 24-hour notice. Your insurance company will not pay for charges when you miss your appointments, therefore you will be responsible for the payment if you fail to attend your schedule appointment.

I, _____, have read and understand the cancellation and no-show policy as specified above. If I should fail to show for a scheduled appointment and have not given 24 hours notice. I agree to pay Fresno Physical Therapy, the sum of $35 for each missed visit.

Patient/ Guardian_____Date_____

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www.fresnophysicaltherapy.com

Chris Mason, PT

Attention Medicare Members

Home health care is defined as either a registered or license vocational nurse providing medically-related services to a patient in a home setting rather than in a medical facility. Home health care may include skilled nursing in addition to speech, occupational and physical therapy.

Are you currently receiving home health benefits or have you recently received home health benefits? Please circle:

YES NO

If yes, please list name of providing company and telephone number and INFORM OUR RECEPTIONIST BEFORE CONTINUING WITH YOUR PAPERWORK.

Home Health Care Provider: _____ Phone #: _____

Failure to notify us may jeopardize your Medicare benefits and *YOU-WILL BECOME RESPONSIBLE* for your physical therapy charges.

Print Name:_____ Date: _____

Patient Signature:_____

Personal Medication List

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Health Problems _____

Primary Doctor _____ **Doctor's Phone** _____

Local Pharmacy _____ **Pharmacy Phone** _____

Drug Allergies _____ **Your Phone** _____

Your Name _____ **Date** _____

Adapted by the American Society of Consultant Pharmacists (ASCP) Foundation
for the Center for Medicines & Healthy Aging

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Instructions for Personal Medication List

- Write the name of each medication you take, the reason, the dose, etc.
- In the last column, write special instructions such as "with food," etc.
- In the over-the-counter section, include vitamins, nutritional supplements, pain relievers, antacids, laxatives and/or herbal remedies.
- Carry the list with you in a purse or wallet with your medical cards.
- Add new medicines when you start taking them.
- Make copies of the blank form so you can use it again as your medications change.
- To save paper, you may want to print this form front and back.

Height_____

Weight_____