southpacific
PHYSICAL THERAPY

4940 Van Nuys Blvd., Ste 301
Sherman Oaks, CA 91403
Ph: (818) 907-0952
Fax: (818) 990-9449

PATIENT INFORMATION **EMAIL ADDRESS:** ____________________

Last Name:	First Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Birth date: Age: ☐ Male ☐ Female	S.S. #:		
Home Phone:	Alternative Phone (Cell):	Spouse:	

Clinic chosen / Referred by ☐ Dr: ☐ Insurance ☐ Family/Friend ☐ Website ☐ Other:

Have you had Physical Therapy this year? ☐ Yes ☐ No When:

WORK INFORMATION

Employer:	Work Phone:	Ext:
Occupation:	Employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone:
Regular Dr./PCP	Regular Dr./PCP Phone:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different):	Birth date:
ID #:	Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name (If different):	Birth date:
ID #:	Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO or WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto: ☐ Worker's Comp:

Adjustor/Claim Manager:	Phone #:	Ext:	
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone #	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:

Relationship to Patient:	Home Phone:	Work Phone:

I authorize my insurance benefits be paid directly to South Pacific Physical Therapy. I understand that I am financially responsible for any unpaid balance. I also authorize South Pacific Physical Therapy to release any information required to process my claims.

____

PATIENT / GUARDIAN SIGNATURE **DATE**

PAST MEDICAL HISTORY FORM

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
MUSCLE CONDITION	**YES**	**NO**
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/ Neck Problems	☐	☐
Limited Limb Movement	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
OTHER CONDITIONS	**YES**	**NO**
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other:____

____

____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _______
☐ 1-2x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _______
☐ 3-4x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _______
☐ 5+x Week	☐ Heavy Labor			

What types of exercise do you perform? ____

What things cause stress in your life? ____

Are you taking any seizure medication? ☐ Yes ☐ No If yes, list name:____________________________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? ☐ Yes ☐ No If yes, list name: ____

List all medications you are currently taking: ____

____

List all surgeries in the past two years (Including dates):____

____

Are you pregnant? ☐ Yes ☐ No What week?: ____________

Have you had any injuries related to work? ☐ Yes ☐ No If yes, list body part and date:_____________________

____

Have you had any Auto Accidents? ☐ Yes ☐ No If yes list body part and date: ____________________________

____

Have you had Physical Therapy before? ☐ Yes ☐ No Where:____________________________________

____ ______________________________

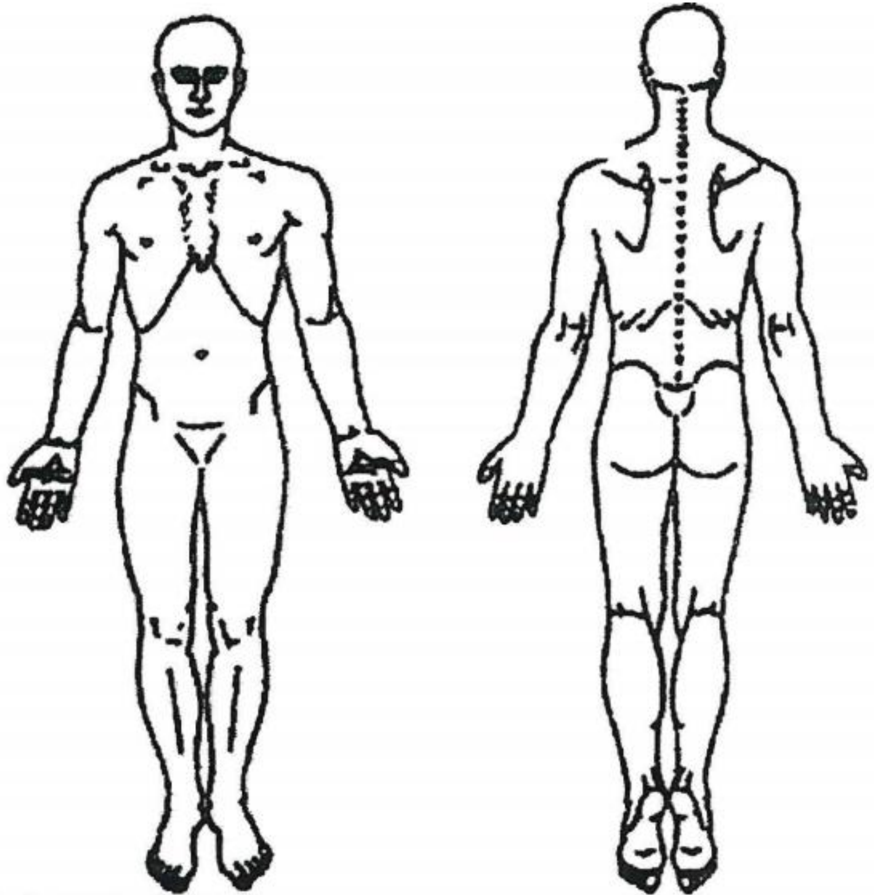
Signature of Patient, Parent, Guardian, Personal Representative **Date**

Pain and Symptom Status Report

Name:____ Date:______________________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning
MMMM MMM	_ _ _ _ _ _ _
Numbness	**Pins and Needles**
O O O O O O O	□ □ □ □ □ □ □
Stabbing	**Other**
/ / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ____

Date First Symptom of your problem occurred on: ____________________________

2nd Complaint: ____

3rd Complaint: ____

Please circle on the scale below to indicate your CURRENT level of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets
Please circle on the scale below to indicate your AVERAGE level of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets
Please circle on the scale below to indicate your WORST level of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Additional Comments: ____

____

Patient's Name____(PLEASE PRINT) **Date:** _______________________

CONSENT TO TREAT

I hereby consent to routine Physical Therapy services as provided by South Pacific Physical Therapy, under the supervision of a licensed physical therapist, according to the general instructions of my physician. I acknowledge that treatment may include any of a number of modalities and/or procedures that will be rendered according to the general or specific instructions of my physician as part of the treatment program provided by this clinic.

To the best of my knowledge, all of the information supplied is true and correct.

INITIALS _________

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand South Pacific Physical Therapy's Notice of Privacy Practices. I understand that South Pacific Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that South Pacific Physical Therapy will consider requests for restriction on a case by case basis but does not have to agree to requests or restrictions. I hereby consent to the use and disclose of my personal health information purposes as noted in South Pacific Physical Therapy's Notice of Privacy Practices. I understand that I retain to revoke this consent by notifying the practice in writing at any time.

INITIALS _________

RELEASE OF MEDICAL INFORMATION

To: ____

Re: ____ Date: ___________________________

You are hereby authorized and requested to furnish to SOUTH PACIFIC PHYSICAL THERAPY, the following medical information (please circle):

X-Ray results Operative Report MRI/CT scan results

Approved by: _________________________

INITIALS _________

____ ____
Patient's Signature Date

____ ____
Signature of Parent or Guardian (relationship) Facility Representative

PATIENT NAME (print): ___________________________________

Dear Patient:

Thank you for choosing us as your health care provider. **The following is our Financial Policy.** Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our billing department. However, we would also encourage you to check your insurance policy for covered benefits for physical therapy services in an out-patient facility setting.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the therapist.

Payment for services is due at the time services are rendered. We accept cash, checks or credit cards. We will be happy to help you process your insurance claim form for our reimbursement as long as you provide us with proper insurance information.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, NOT with your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Again, our suggestion to you is to get familiar with what your policy covers.
3. Fees for non-covered services, along with co-payments are due at the time of treatment. Please note that you will be billed for deductible and/or co-insurance fees once your insurance processes your claims for all dates of service. You are more than welcome to make intermittent payments as you receive Explanation of Benefits (EOB's) form your insurance company. The EOB's will show the portion you owe us, the provider.
4. If the insurance company does not pay your claim, you may be asked to contact them to help speed things up.
5. If you have a work related injury and you are a member of a Preferred Provider Group, such as a PPO or an HMO, we are entitled to 100% of the normal and customary physical therapy charges upon collection of damages by the way of settlement.
6. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges.

IMPORTANT:

PLEASE NOTE THAT, UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, YOU MAY BE CHARGED FOR MISSED APPOINTMENTS AT THE RATE OF $40.00/MISSED VISIT. Please call to re-schedule on a timely manner. Your cooperation would be much appreciated.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

PATIENT SIGNATURE ____ DATE ___________________