



Mt. Shasta Physical Therapy
633 Lassen Lane, Mt. Shasta, CA 90607
Tel: 530-926-6010
www.mtshastapt.com

APPOINTMENT INFORMATION SHEET

Patient Name: _____

Appointment Day/Time: _____

For your first appointment, please bring your:

- Doctor's prescription.
- Completed paperwork (unless already completed on-line).
- Insurance card(s).
- Personal identification with photo.
- Also wear or bring shorts if you are being treated for a lower extremity injury.

Please refrain from wearing perfumes and colognes to your scheduled appointments.

Cancellations and Missed Appointments:

- Please arrive on time for all appointments.
- Notify us at your earliest convenience if you need to cancel or reschedule an appointment.
(24 hours minimum; emergencies and sudden illness excepted.)
- Missed appointments or those cancelled with insufficient notice will be subject to a \$25 charge. (Not reimbursable by your insurance.)

Payment for Physical Therapy Services:

- Charges are determined by the type of service provided and the amount of time spent by the therapist.
- Co-payments are expected at the time of service.
- Discounts are available for cash patients.
- Individuals may make specific arrangements for payment.

We look forward to seeing you and being a part of your rehabilitation.

Sincerely,

Linda Stremel, P.T. Jennifer Pentrack, P.T. Sandra Joan Skiff, P.T.
Susan Spence, P. T. Jason C. Koster, P.T. Joe Champagne, P.T. Karee Barham, P. T. A.

The Wellness Center

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**PHYSICAL THERAPY ADMISSION
QUESTIONNAIRE**

NAME: _____
(First) (Middle) (Last)

MAILING ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

AGE: _____ BIRTH DATE: _____ SEX: M F EMAIL: _____ SPOUSE: _____

Problem/Main reason for physical therapy: _____

Related surgeries and dates: _____

Date Problem Began/How did it happen? _____

MEDICAL HISTORY:

Do you have any of the following symptoms?

	YES	NO
Pain:	<input type="checkbox"/>	<input type="checkbox"/>
Nausea:	<input type="checkbox"/>	<input type="checkbox"/>
Balance Difficulties:	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness:	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>
Headache:	<input type="checkbox"/>	<input type="checkbox"/>
Swelling:	<input type="checkbox"/>	<input type="checkbox"/>
Weakness:	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the following conditions?

	YES	NO
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>
Open Sores:	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia:	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

METAL IMPLANTS: _____ Please describe: _____

ALLERGIES: _____ Please describe: _____

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? Please describe: _____

MEDICATIONS YOU ARE CURRENTLY USING:

Medication:	To treat what?
_____	_____
_____	_____



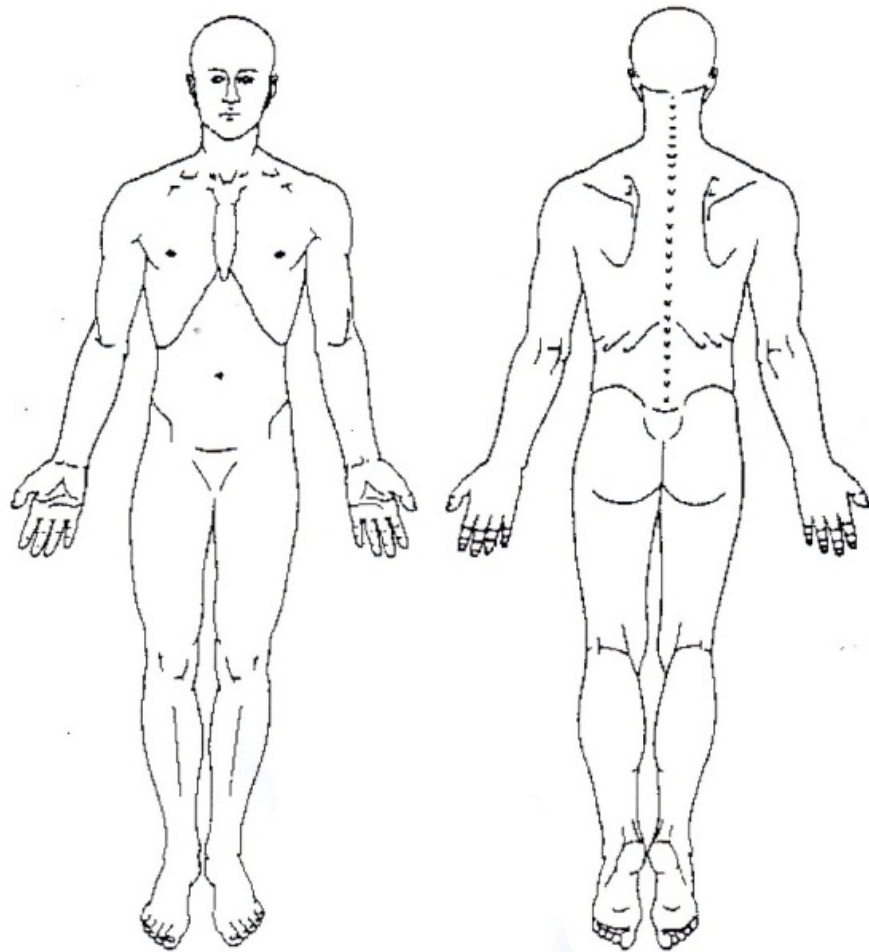
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PAIN DRAWING INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY

Stabbing	Burning	Pins & Needles	Numbness	Aching
////	XXXX	OOO	===	-----
////	XXXX	OOO	===	-----



Patient: _____

Date: _____



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Financial and Cancellation Agreement

"I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on the patient information sheets. I certify the information I have given is true and correct to the best of my knowledge. I will notify you of any changes of the above information."

It is Mt. Shasta Physical Therapy's policy to turn delinquent accounts over to a collection agent for payment funds. **Co-pays and deductibles are required at time of visit.** If full payment cannot be made at time of visit we will be glad to work out payment arrangements with you.

"I understand and agree that, it is necessary to contact Mt. Shasta Physical Therapy within 24 hours if I cannot keep an appointment. If no effort is made to cancel appointment, a service charge of \$25.00 (not reimbursable by my insurance) will be made for which I will be responsible."

Patient Signature _____ *Date* _____

Print Name _____

Parent Signature (If patient is a minor) _____ *Date* _____

Print Name _____

(OVER)



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AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment for physical therapy services that I am to receive to be paid directly to Mt. Shasta Physical Therapy. I also authorize Mt. Shasta Physical Therapy to release any information required by my insurance in order to process claims.

Patient Signature: _____ Date: _____

Printed Name: _____

(If signed by other than patient, please indicate relationship: _____)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize release of any medical records that may be helpful in my treatment to be sent to Mt. Shasta Physical Therapy, and I authorize release of my records from Mt. Shasta Physical Therapy to be sent to my physician.

Patient Signature: _____ Date: _____

PRINTED NAME: _____

(If signed by other than patient, please indicate relationship: _____)



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CONFIDENTIALITY NOTICE

In general, it is Federal Policy that we do not disclose information about YOU to ANYONE ELSE without permission. This policy includes a spouse, son, or daughter, parent, in certain cases, or anyone who might inquire as to your health and/or account information. We need your permission to leave messages on an answering machine, or give the information to a family member who may answer your telephone.

I, _____ give permission that messages regarding appointments may be left on my answering machine or given to the person answering the phone.

Please list the names of relatives or friends that may inquire as to my health, appointments, or account status. **If a spouse is not listed, we will assume information should not be left with them.**

I hereby authorize you to release information to the following people:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Patient Signature _____ Date _____

(This authorization is for family members or friends ONLY. It is my understanding that information must be released to my insurance company upon request, or to auxiliary medical services, such as hospitals, laboratories, pharmacies, etc.)

OR...

It is my wish that information regarding my health, appointments and account status NOT BE RELEASED to ANYONE OTHER THAN MYSELF.

Patient Signature _____ Date _____

(OVER)



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**Mt. Shasta Physical Therapy
Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Mt. Shasta Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Mt. Shasta Physical Therapy. I understand that diagnosis or treatment of me by Mt. Shasta Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Mt. Shasta Physical Therapy is not required to agree to the restrictions that I may request. However, if Mt. Shasta Physical Therapy agrees to a restriction that I request, the restriction is binding on Mt. Shasta Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Mt. Shasta Physical Therapy has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Mt. Shasta Physical Therapy’s Notice of Privacy Practices prior to signing this document. The Mt. Shasta Physical Therapy’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment, of my bills or in the performance of healthcare operations of Mt. Shasta Physical Therapy.

The Notice of Privacy Practices for Mt. Shasta Physical Therapy is also provided at the receptionist’s desk. This Notice of Privacy Practices also describes my rights and the Mt. Shasta Physical Therapy’s duties with respect to my protected health information.

Mt. Shasta Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for it at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____ (Printed)

Description of Personal Representative’s Authority _____

To respect your privacy, please tell us which of the following number we should call you to communicate with you regarding Appointment Reminders, Lab Results, etc. Only list numbers you want us to call.

Home: _____ Work: _____ Cell: _____

Other: _____

Patient's Name (Please Print) _____

Patient's Signature _____

(OVER)

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Mt. Shasta Physical Therapy and Wellness Clinic*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: (accessing our website @ www.mtshastapt.com or telephone us at (530) 926-6010.

If you have any questions about our *Notice of Privacy Practices*, please contact:

I acknowledge receipt of the *Notice of Privacy Practices of Mt. Shasta Physical Therapy and Wellness Clinic*.

Signature: _____ Date: _____
(Patient/Parent/Conservator/Guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and reasons why the acknowledgement was not obtained.

Signature of Provider Representative: _____ Date: _____

This section applies only if your Covered Entry has reserved the right to change its privacy practices. It is recommended that providers reserve this right.