



**Mt. Shasta Physical Therapy**  
633 Lassen Ln., Mt. Shasta, CA 96067  
Tel: 530-926-6010  
[www.mtshastapt.com](http://www.mtshastapt.com)

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## APPOINTMENT INFORMATION SHEET

All appointments for new patients will require a one-time, refundable deposit of \$50.00 to secure your appointment. You may use cash, check or credit card. The check or credit card will not be cashed or charged unless you do not show to your initial appointment. Upon arrival of your initial appointment, we will return any monies you have left as a deposit. If you do not show to your appointment, your deposit is non-refundable.

**Patient Name:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**PLEASE Arrive 15 Minutes Early For Your First Appointment and BRING Your:**

- Doctors Prescription
- Completed Paperwork (unless already completed online)
- 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 or Colognes To Your Scheduled Appointments.**

### **Cancellations and Missed Appointments:**

- Please arrive on time for all future appointments.
- If you need to cancel or reschedule an appointment, notify us at your earliest opportunity. Mt. Shasta Physical Therapy requires a minimum of 24 hours' notice.
- Missed appointments, or those cancelled within 24 hours of appointment time, will be subject to a \$35 fee. (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 with the therapist.
- Co-payments are expected at the time of service.
- Discounts are available for cash patients.
- If full payment cannot be made at the time of your visit, we will be happy to work out a payment arrangement with you.

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

Sincerely,

Linda Stremel, P.T.

Joe Champagne, P.T.

Lucia Pizano, P.T.A.

Carol Winston, P.T.

Jason C. Koster, P.T.





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## PHYSICAL THERAPY ADMISSION QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Main Reason for Physical Therapy: \_\_\_\_\_

Date Problem Began: \_\_\_\_\_

If an accident, how did it happen? \_\_\_\_\_

List Any Related Surgeries and Dates: \_\_\_\_\_

### 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"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Open Sores	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis / Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>

METAL IMPLANTS: \_\_\_\_\_ Please Describe: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ Please Describe: \_\_\_\_\_

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? Please describe:

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?  X-Ray  MRI  CT Scan  Myelogram

Results of the Test(s):

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PREVIOUS HOSPITALIZATIONS and/or OTHER SURGERIES – Reason and Date: (Most recent one first)

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ACTIVITIES/LIFESTYLE:

What is your current activity level?

Sedentary       Light       Moderate       Heavy       Very Heavy

Activity level before current problem:

Sedentary       Light       Moderate       Heavy       Very Heavy

Activities that you currently find difficult, or unable to do:

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Hobbies and Recreational Activities:

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Are you currently working?     Yes     No      If No, Date last employed: \_\_\_\_\_

If Yes, Describe Your Job: \_\_\_\_\_

Do you live alone?                       Yes     No

If yes, do you have help at home?     Yes     No

Do you have steps or stairs at home?     Yes     No

If yes, do they have hand railings?     Yes     No

How many times have you fallen in the past 3 months? \_\_\_\_\_

How many times have you fallen in the last year? \_\_\_\_\_

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Name and Address of Doctor (**other than your referring physician**) where you wish to have your initial report sent:

\_\_\_\_\_  
Doctor Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Doctor Mailing Address

WHERE DID YOU HEAR ABOUT MT. SHASTA PHYSICAL THERAPY?

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## PAIN DRAWING

INSTRUCTIONS: Indicate where pain is located and what type of pain you feel at the present time. Use the symbols below to describe the pain.

### SYMBOL KEY

Stabbing:

/////  
/////  
/////  
/////

Burning:

X X X X  
X X X X

Pins & Needles:

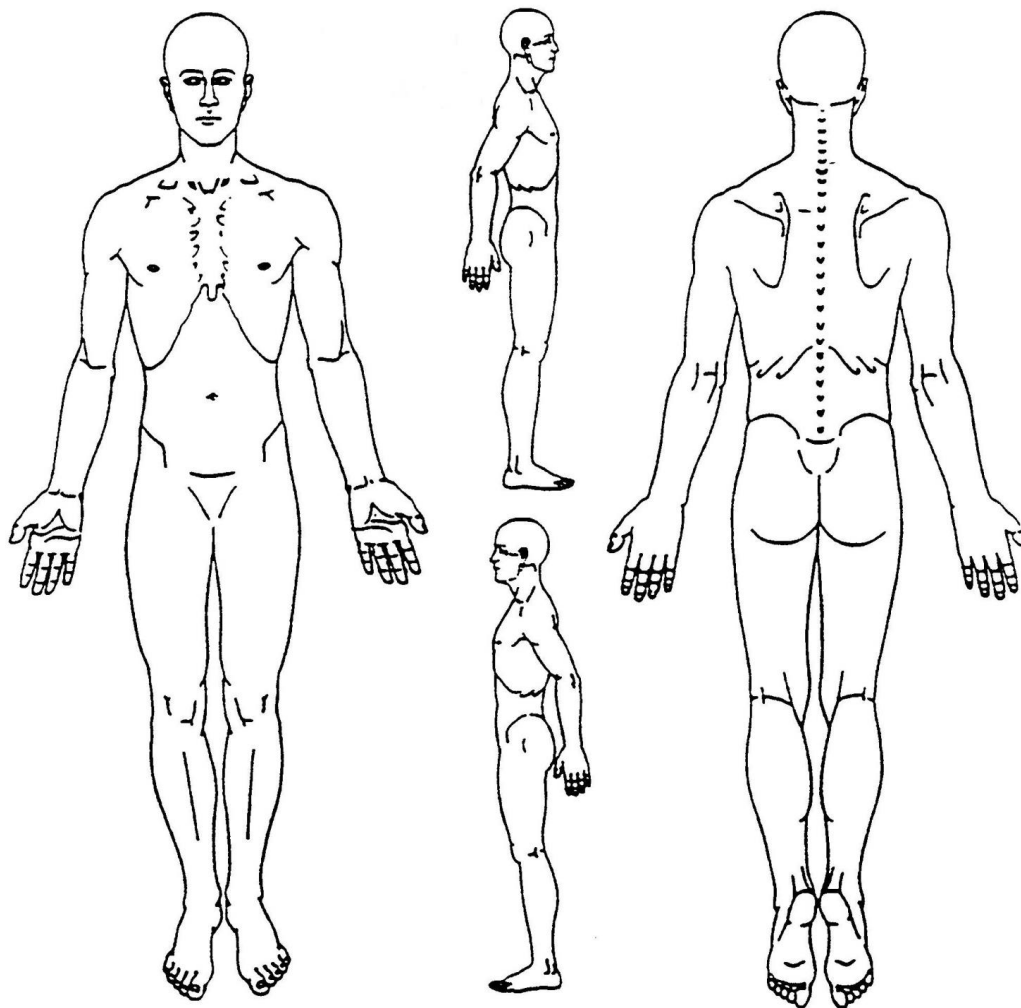
O O O O  
O O O O

Numbness:

= = = =  
= = = =

Aching:

# # # #  
# # # #



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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## Medication List

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**\*PLEASE PRINT.** *It is important that we can read your current medications.*

	Medication Name	Dosage / Frequency	Method of Delivery (oral, injection, etc.)	Condition being treated?
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____



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## CONFIDENTIALITY NOTICE

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

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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

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

**Patient Signature:** \_\_\_\_\_

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

**I hereby authorize release of my information to the following persons:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OR...**

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## FINANCIAL AND CANCELLATION AGREEMENT

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

- "I understand and agree that, as a new patient, I will need to make a refundable \$50.00 deposit to secure my appointment time, which is not refundable if I do not show to my initial appointment."
- "I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered."
- "I understand and agree that, if I need to cancel or reschedule an appointment, I will notify Mt. Shasta Physical Therapy at my earliest opportunity. If I miss my appointment or cancel within 24 hours of my appointment time, I will be subject to a \$35.00 fee, not reimbursable by my insurance, for which I will be responsible to pay."

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature,  
If patient is a minor:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature,  
If patient is a minor:** \_\_\_\_\_

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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 company in order to process claims.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature,  
If patient is a minor:** \_\_\_\_\_



# Mt. Shasta Physical Therapy – Summary of Notice of Privacy Practices

## Consent for Purposes of Treatment, Payment, and Healthcare Operations

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

- 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 I have the right to request a restriction as to how my protected health information is used or disclosed in order to carry out treatments, payments, 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 support of this consent.
- I understand that my diagnosis and/or treatment by Mt. Shasta Physical Therapy may be conditional as evidenced by my signature on this document.
- I understand that this is a summary; however, I have the right to review the full **Notice of Privacy Practices** prior to signing.

The **Notice of Privacy Practices** describes in detail the types of uses of my protected health information that will occur in my treatment, payment of my bills, and in the performance of healthcare operations of Mt. Shasta Physical Therapy. The **Notice of Privacy Practices** also describes my rights, and Mt. Shasta Physical Therapy’s duties, with respect to my protected health information. A copy of the **Notice of Privacy Practices** in its entirety is available at the receptionist’s desk.

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

I understand that by signing this form, I am consenting to treatment by Mt. Shasta Physical Therapy.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Print Name:**

\_\_\_\_\_  
**Parent Signature** (If patient is a minor)

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Signature of Personal Representative** (If unable to obtain patient signature)

\_\_\_\_\_  
**Description of Personal Representative’s Authority**



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**Email Request Form**

In an effort to better connect with our patients, MSPT is requesting your personal email address so we may easily communicate appointment reminders, schedule changes, wellness topics & upcoming events. We will only use the email address you provide for Mount Shasta Physical Therapy and/or Mountain Fitness communications that may be of benefit to you.

Mount Shasta Physical Therapy will never share your personal email address with any third party.

**PLEASE PRINT**

Email Address: \_\_\_\_\_ @ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_