Patient Information Form

New Patient Return Patient

Patient Name____
First *Last* *MI*

Address____
Street or P.O. Box *City* *State* *Zip*

Home Phone___________________________________ Cell Phone____

Email____ Social Security#_______________________________________

Date of Birth___________________________________ Age_____________ Male Female

Patient Status: Single Married Widowed Other

Person Financially Responsible____ Phone_________________________

Address____

Relationship to Patient____

Additional Information *(required)*

Employer____ Phone_________________________

Address____ Job Description_________________________

Are you a student? Yes No Full time Part time May we call you at work? Yes No

Insurance Information *(required)*

Primary Insurance_______________________________ Secondary Insurance__________________________________

Policy#____ Policy#____

Group#____ Group#____

Is the patient the subscriber? Yes Is the patient the subscriber? Yes

No (fill out below) No (fill out below)

Subscriber Name________________________________ Subscriber Name______________________________________

SS#____ SS#____

Date of Birth ___________________________________ Date of Birth____

Relationship____________________________________ Relationship____

Doctor/Emergency Contact *(required)*

Referring Doctor______________________________ Primary Doctor____________________________________
First Name Last *First Name Last*

Date Last Seen_______________________________ Date Last Seen____________________________________

Emergency Contact Name_________________________________ Relationship______________________________

Emergency Contact Phone_________________________________

Injury or Onset of Pain Information *(required)*

Diagnosis____________________________________ Date of Injury/Onset of Pain__________________________

Auto Related* Work Related*

*If related to an auto accident, have you retained an attorney? Yes No

Insurance Adjusters Name_____________________________________ Phone______________________________

Attorney____ Phone______________________________

Attorney Address____

Signature Date

Youthful Horizons
Therapy for Children & Adults

Patient History

Today's Date Date of Birth

First Name Last Name MI

Please describe your condition or symptoms:

Cause of the above

Auto Accident Sports Injury On the Job Injury

Illness Unknown Other

Have you missed any work due to your condition? Yes No

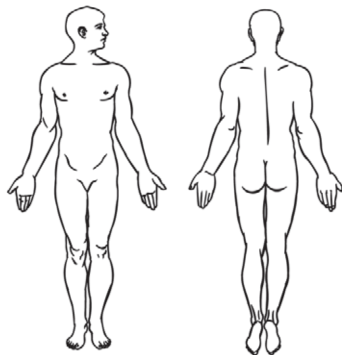
Date your condition or symptoms began____

Date initially seen for this condition________________________ By Dr.______________________________

Please rate your pain level: 0 – 10 *(0=no pain, 10=severe/extreme)*

Current____ Best____ Worst____

Using the diagram, circle the specific area of pain. If pain travels, draw arrows.



How would you describe your pain?

none	dull ache	deep ache	stabbing
nagging	throbbing	squeezing	drawing
burning	heavy	twinge	cramp
sharp	sore	continual	other

Do you have numbness or tingling? Yes No If yes, where?________________________________

Prior to onset, were you free of these symptoms? Yes No Explain_____________________________

What eases these symptoms?____

What aggravates these symptoms?____

Have you had any treatment for this condition? Yes No Did it help?________________________

What type and where? ____

Since your last treatment, are you getting: better worse same

Have you had X-rays? Yes No Findings____

Please list any other tests you have received____

General Medical

Check if you have ever been diagnosed with any of the following conditions:

Parkinson's Disease	Multiple Sclerosis
Cancer, What type___________________________	Hepatitis
Heart Problems	Tuberculosis
High blood pressure	Stroke
Asthma	Kidney disease
Emphysema	Anemia
Chemical dependency (alcohol or drug)	Epilepsy
Thyroid problems	Insomnia
Diabetes	Constipation/diarrhea
Rheumatoid arthritis	Dementia
Other arthritic problems	Depression
Other	

Please list any surgeries or injuries (fractures, dislocations, sprains, etc.) for which you have been treated or hospitalized. Include approximate dates.

____

____

____

Please list or attach all prescription and over-the-counter medications you are currently taking

____

____

____

What are the most important things you hope to accomplish with physical therapy?

____

____

____

____

Signature Date

Authorization/Consent Form

Patient Name____

Authorization for Treatment

I consent to the treatment necessary for the above named patient, including physical therapy, occupational therapy, speech therapy, aquatic therapy, massage therapy, and/or any other related services that the provider or physician advise to be necessary.

HIPPA Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Restrictions

____

____

____

Individuals Allowed Access

____

____

____

Cancellation/No-Show Policy – Please call 24 hours in advance to cancel.

We will send you a warning letter regarding your potential discharge after your 2nd missed visit. If there are 3 missed visits in a one-month period, you will be discharged from therapy. A letter will be sent to your primary care physician (PCP) explaining the reason for the discharge from our services. This will potentially cause a loss of your preferred time slot. In order to resume services you will need to obtain a new referral from your PCP and reschedule. We do understand there are special circumstances that can occur and we will review those carefully before making our final decision.

Payment/Insurance Authorization

I authorize for all insurance payments to be made directly to Youthful Horizons Physical Therapy, P.S. for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if DSHS, Healthy Options Coupon or my insurance denies service. Thank you!

I have read and fully understand the above consent for treatment, release of medical information, and payment/ insurance authorization. I have fully read and agree to the cancellation/no-show policy as described above.

I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me. I authorize the below-named provider to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related Medicare Claim. I acknowledge that I have read and understand the Medicare Authorization. I further permit a copy of this authorization to be used in place of the original.

Provider's Name: Youthful Horizons Physical Therapy, P.S.
Provider's Address: 325 S. University Rd., Spokane Valley, WA 99206

____
Please Print (Patient or Parent/Guardian)

____
Signature (Patient or Parent/Guardian) Date

If signed by Patient representative, state relationship to patient____

Authorization to Release Medical Records

Records to be Released From/To

Business Name: **Youthful Horizons Physical Therapy**

Address: **325 South University Road**

City, State, Zip: **Spokane Valley, Washington 99206**

Records to be Released To/From

Business Name____

Address____

City, State, Zip____

Patient Information

Patient Name____

Address____

City, State, Zip____

Date of Birth_______________________________ Phone Number______________________________________

Social Security Number____________________________________

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
6. This authorization shall expire upon my written request to revoke or according to state law;
7 A copy of this authorization is valid as the original.

____

Signature of Patient or Patient Representative Date

____

Description of Representative's Authority to Act for Patient