Compass
Physical Therapy

Confidential Patient Information

Patient Name:_____Date of Birth:_____
S.S. # _____ Marital Status: M D S W Gender: Male/Female
Home Address:_____
Cell Phone:_____ Home Phone:_____
E-mail:_____
Employer:_____ Work Phone:_____
Referring Physician:_____ Phone:_____
Primary Care Physician: _____ Phone:_____
Injured Body Part (s): _____
Date of Injury or Onset of Symptoms: _____ Date of Surgery:_____

Emergency Contact: _____ Phone:_____
Relation to Patient:_____

Primary Insurance:_____Phone:_____
Subscriber Name:_____Date of Birth:_____ S.S. #:_____
Relationship to Patient:_____ I.D./Claim #:_____
Secondary Insurance:_____Phone:_____
Subscriber Name:_____Date of Birth:_____ S.S. #:_____
Relationship to Patient:_____ I.D./Claim #:_____

Auto Claim Information
Insurance:_____Phone:_____
Adjuster Name:_____ Claim#_____
Date of Accident:_____ MedPay Remaining:_____

Patient/Guardian Signature:_____ Date:_____

Compass Physical Therapy

For Office Use Only:

LB:	Auth:	Prior PT: Y or N
HT:	MD:	Previous PT: Y or N
BP: /	INS:	Minor: Y or N
HR:	O2	Guardian:

Name:_____ Age:_____ Place of Employment:_____

Gender (circle): Male or Female

Dominant Hand (circle): Right or Left

How did you hear about **Compass Physical Therapy**? (Please check)

Physician Referral:____Online:_____Friend/Family:_____ (Name)_____

Other (Please explain):_____

When did this injury or accident occur? Month:_____ Day:_____Year:_____

Was this injury job related?_____ If yes, have you filed for Worker's Compensation?_____

If this injury is not job related, how did it happen?_____

_____

What body parts are currently affected?_____

When did your symptoms begin occurring? (**Please check**) Immediately?_____ Gradually?_____

Since this condition began are your symptoms: Increasing____ Decreasing____ No change____

How much of the day do you feel your symptoms?

Occasional (10-25%)____ Intermittent (26-50%)____ Frequent (51-89%)____ Constant (90-100%)____

Choose below which most accurately describes your symptoms:

____Pain is annoying but able to perform all activities.
____Pain is tolerated but may cause difficulty performing some activities.
____Pain interferes with performance of all activities.
____Pain is so severe that you are unable to perform any activity.

How are you sleeping at night? Good____ Fair____ Poor____

What makes you condition feel worse?

Nothing____ Sitting____ Standing____ Walking____ Running____ Stairs____ Kneeling____ Bending____
Twisting ____ Lifting____ Writing____ Typing____ Other:_____

What makes your condition feel better?

Nothing____ Lying Down____ Sitting____ Walking____ Stretching____ Movement____ Exercise____
Manipulation____ Medication____ Other:_____

What treatments have you already received for this condition?

None____ Physical Therapy____ Surgery____ Chiropractic____

Diagnostics Tests: CT Scan____ EMG/NCV____ MRI____ X-Ray____

What medications are you taking for this condition?

1._____ x day (circle) am/pm

2._____ x day (circle) am/pm

What medications are you taking for other conditions?_____

Have you fallen in the last year? Yes____ No____ If you answered yes, how many times have you fallen?_____

Have any of these falls resulted in injury? Yes____ No____

Have you received home health care for this condition? Yes____ No____

If yes, on what date were you discharged from home healthcare?_____

Medical History (Please check all that apply):

___History of Cancer ___Cardiovascular Disease ___Major Motor Weakness ___Lupus

___Osteoarthritis ___Fibromyalgia ___Traumatic Brain Injury ___Obesity

___Parkinson's ___High Blood Pressure ___Rheumatoid Arthritis ___Stroke

___Diabetess Type 1 ___Diabetes Mellitus Type 2 ___Fracture or Suspected Fracture

___Due to MVA or Industrial Injury ___Recent Onset Bladder Dysfunction

___None of the above ___Other:_____

Hobbies/Activities:_____

Are you currently working? Yes____ No____ If no, last date worked:_____

Do you have any work limitations? Yes____ No____ If yes, limitations:_____

How would you describe your overall health? Poor____ Fair____ Good____ Excellent____

Rate your current pain: (circle one) Low 1---2---3---4---5---6---7---8---9---10 High

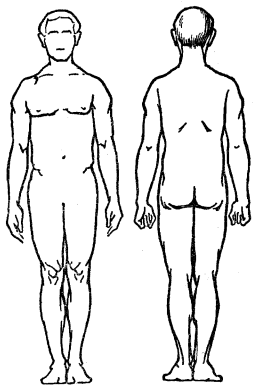
Mark on the picture below where you have pain or symptoms:

// = numbness

.. = burning

^ = tingling

~ = pain



Patient/Parent Signature:_____ Date: _____

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Patient Name:_____ Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of my medical record to my health insurance plan as needed to determine insurance benefits support adjudication and payment of my health insurance claim. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested.

Initial:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

Initial:_____

NO CELL PHONE POLICY

We ask that you please restrain from using your cell phone in this office. We understand circumstances and emergencies do occur and we ask that you please step out to use your phone in these instances. Thank you.

Initial:_____

ASSIGNMENT OF MY BENEFITS

I hereby instruct and direct _____ insurance company to pay by check made out to Compass Physical Therapy and mail to the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the address on the right for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Compass Physical Therapy
921 G Street
Reedley, CA 93654

I understand that insurance billing is provided as a courtesy and that I assume financial responsibility for any charges not covered by my insurance plan. While Compass Physical Therapy verifies benefits directly with my insurance plan; exact benefits cannot be determined until the insurance plan receives the claim.

Initial:_____

CO-PAYS

We are required by our insurance contracts to collect all co-pays amounts at the time services are rendered.
We accept cash and most major credit cards.

Initial:_____

Patient/Guardian Signature:_____ Date:_____

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Cancellation Agreement

There is a $35.00 charge for cancellations or "no shows"

We realize your time is valuable. This is why we have reserved an appointment just for you. We know that emergencies happen which may affect your ability to keep your reservation. If you have an emergency or are unable to keep your scheduled appointment, contact our office immediately, that way we know you are OK and so that we reschedule your cancelled visit. We do reserve the right to charge you $35.00 for missed appointments.

To avoid this charge, contact our office 24 hours prior to your scheduled appointment. Thank you for your understanding.

Signature: _____

Date: _____

Witness: _____

Date: _____