PHYSICAL THERAPY SPECIALISTS
EST. 1994

@ The Pad

New Patient Intake

Please complete this form in its entirety.

PATIENT

Prefix: DR MR MISS MS MRS **Name:** _____
First MI Last Suffix

Birthdate: _____/_____/_____ **Nickname:** _____

Mailing Address: _____
Street City State Zip

Physical Address (if different): _____
Street City State Zip

Primary: HOME CELL **Phone:** Home: _____ Cell: _____

Patient's SSN: _____-_____-_____ **Gender:** M F **EMAIL ADDRESS:** _____

Marital Status: DIVORCED SEPARATED SINGLE MARRIED WIDOWED

Employment Status: ACTIVE MILITARY FULL TIME PART TIME RETIRED SELF EMPLOYED UNEMPLOYED

Employer: _____ **Student Status:** FULL TIME PART TIME NOT A STUDENT

Emergency Contact: _____ **Phone:** _____
First Last
(Please circle one)

Relationship: _____ This person has permission to discuss my care/account: **YES** **NO**

PARENT/GUARDIAN - (FOR MINORS ONLY)

Parent/Guardian Name: _____
First MI Last Suffix

Address: _____
Street City State Zip

Guarantor Phone: _____ **Birthdate:** _____/_____/_____ **Gender:** M F

Parent/Guardian SSN: _____-_____-_____

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Medical History

In order to provide you with the highest quality of care, please complete this medical questionnaire thoroughly.

INJURY DETAILS

Which body part are you seeking treatment for today: _____ **Side:** LEFT RIGHT

Was your condition caused by some form of accident/injury? YES NO

Type of accident/injury: _____ **Date of injury:** _____/_____/_____

Have you received any of the following services <u>this calendar year</u>?

Home Health Care	YES	NO	Occupational Therapy	YES	NO
Physical Therapy	YES	NO	Chiropractic Care	YES	NO
Speech Therapy	YES	NO	Surgical Procedures	YES	NO

Have you had any hospital admissions <u>this calendar year</u>? YES NO **If yes, why?** _____

MEDICAL HISTORY

Do you now or have you ever had any of the following:

High Blood Pressure	YES	NO	Sensitivity to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Cancer	YES	NO

If you are currently taking any medications, please list below or attach the types, dosages, and frequency:

_____

Please list any drug or material allergies you have: _____

Female patients only, please indicate if you are currently pregnant: YES NO

The above information is true and correct to the best of my knowledge. I herby authorize Physical Therapy Specialists to render treatment at The Pad located at 888 Ricardo Ct, San Luis Obispo, CA. I am aware that these services are rendered on a cash pay basis and I agree that my insurance will not be billed nor will any insurance contracted rates apply to any of the services I receive.

_____ _____

Signature of Patient Date

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Notice of Privacy Practices

We are required by law to provide you with information regarding your rights and the privacy practices of PTS. We are committed to maintaining the privacy of your protected health information. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by PTS. PTS may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the patient (or the patient's personal representative) authorizes in writing.

We are permitted by certain laws to use and disclose your medical information without your authorization for the following purposes or situations: (1) To the Patient (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. We will always practice professional ethics and best judgment in deciding which of these permissive uses and disclosures to make. Records may be stored by paper or stored electronically.

PTS must obtain written consent for any use or disclosure of protected health information that is not for treatment, payment, health care operations, or otherwise permitted or required by the Privacy Rule. If you authorize PTS to disclose and/or discuss your protected health information, including appointments and billing, to another individual, please provide their information below:

_____ _____
Printed Name of Authorized Individual Relationship

The Privacy Rule requires PTS to treat a "personal representative" the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule. A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when PTS has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, it will be at the discretion of PTS to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

If you have any questions or concerns regarding your protected health information or this notice, please contact our office at (805) 473-7499. If you believe your rights have been violated, you may submit a formal written complaint to our office at P.O. Box 2638, Pismo Beach, CA, 93448-2638.

By signing below, you acknowledge you have read and understand the aforementioned, and are authorizing PTS to initiate appeals with your insurance pertaining to care received at this facility.

_____ _____
Signature of Patient Date