DEL MAR PHYSICAL THERAPY

Patient Information

Date _____

PLEASE PRINT CLEARLY

Name_____ Birthdate_____
Last First M.I. MM/DD/YYYY

Age_____ Sex M / F Marital Status _____SS#_____

Address_____City_____Zip_____

Phone (____)_____Work (____)_____Cell (____)_____

Email_____

****

Emergency Contact _____ Relationship_____

Phone (_____)_____

Was Injury *Personal Accident* Yes / No *Auto Related* Yes / No *Employment Related* Yes / No

Prior Physical Therapy THIS YEAR: Yes / No
If YES please indicate:

Last date of treatment _____ # of Visits _____

Facility Name/Location_____

Ph (_____)_____

Are you currently receiving / received in the last **30 days** Home Health from anyone for any procedure? Yes / No
Agency_____

Contact_____ Phone (_____)_____

****

*Responsible Party Information (*if other than above or Minor under 18yrs)

Name_____Employer_____

D.O.B. _____ Relationship to Patient_____

Address_____City:_____ Zip:_____

SS# _____ Phone (_____)_____

****

Referred By_____

DEL MAR PHYSICAL THERAPY

TO OUR MEDICARE PATIENTS:

Please read the following changes to Medicare effective beginning **January 1, 2013**.

NOTICE OF FINANCIAL LIMITATION
Medicare has placed an annual financial limit (cap) on therapy services limiting the amount of services that will be covered in a calendar year for Medicare beneficiaries. The calendar year starts on January 1 and ends on December 31.

The 2013 limitations (caps) are as follows:
$1,900.00 for Physical Therapy and Speech Therapy services combined, and
$1,900.00 for Occupational Therapy services. This cap equates to 20 visits per calendar year.
The therapy caps are the ONLY capped services under Medicare. Services provided in hospital-based outpatient clinics are exempt from the cap.

HOW DOES THE CAP WORK?
Medicare bases the cap on the allowable charges covered by Medicare. After you have met your Medicare deductible of $140.00, Medicare will pay 80% of the $1900= $1520. You or your supplemental insurance will be responsible for 20% of the $1900 = $380.00. These numbers are based on the annual therapy cap.

WHAT HAPPENS WHEN THE CAP IS REACHED?
If your therapy services will exceed the cap you have some choices. You can:
1. Continue therapy on a self-pay basis, OR
2. Continue therapy in a hospital setting which is exempted from the cap, OR
3. Discharge yourself from therapy.

DISCLAIMER
We do not support the limitation that Congress has imposed on the benefits that you receive under Medicare. We will work with you to ensure that you receive the necessary care that you need within the allotted cap.

Please sign and date below, acknowledging that you have read the above statements and understand financial limitations instituted by Medicare and personal financial obligations.

Your signature authorizes release of any medical information necessary to process claims and authorizes Medicare to pay Del Mar Physical Therapy for the services provided.

Patient Name: _____ Date: _____

Signature: _____

ASSIGNMENT AND DIRECT PAYMENT

PATIENT: _____

SUPPLEMENT INSURANCE: _____

GROUP #: _____POLICY/SUBSCRIBER ID: _____

I hereby instruct and direct that _____ insurance company to remit payment directly to:

Del Mar Physical Therapy
317 14 th Street
Del Mar, CA 92014

or

If my current policy prohibits direct payment to the therapist, I will hereby instruct and direct the insurance company to make out the check to me and mail as follows:

C/O **Del Mar Physical Therapy**
317 14 th Street
Del Mar, CA 92014

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY. The payment issued by my insurance company to provider will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a timely manner, any balance of any and all professional service charges over and above the insurance payment,

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorized the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize therapist to file complaints directly to the California Insurance Commissioner, if the need arises.

Signature of Policyholder _____ Date _____

Signature of claimant
(if other than Policyholder) _____ Witness_____

Del Mar Physical Therapy

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Del Mar Physical Therapy's **Notice of Information Practices.** I understand that Del Mar Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Del Mar Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Del Mar
Physical Therapy

Del Mar Physical Therapy is required to inform you of your rights and the following information. Your signature below is required for your medical records.

The Physical Therapy Board of California licenses and regulates your Physical Therapist. Visit the Board's website at www.ptbc.ca.gov for information on:

- Verifying a license
- What to expect when you receive care
- Your rights as a patient
- How to file a complaint

Physical Therapy Board of California
2005 Evergreen Street, Suite 1350
Sacramento, CA 95815
1-800-832-2251

Thank you,

Del Mar Physical Therapy

Patient Signature _____ Date _____

317 14th Street, Suite B • Del Mar, CA 92014 • **858.755.1229** • Fax: 858.755.0720
delmarphysicaltherapy.com

Patient Name: _____ Patient ID _____

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

☐ At least 3 times a week ☐ Once or twice per week ☐ Seldom or never

Other health problems may affect your treatment. Please check any of the following that apply to you:

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer

Height: _____ ft. _____ in. Weight: _____ lbs.

This is a statement other patients have made. ***"I should not do physical activities which (might) make my pain worse."*** Please rate your level of agreement with this statement below. (✓*response*)

- ☐ Completely Disagree
- ☐ Somewhat Disagree
- ☐ Unsure
- ☐ Somewhat Agree
- ☐ Completely Agree

physiquality

Patient Health Questionnaire - PHQ

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

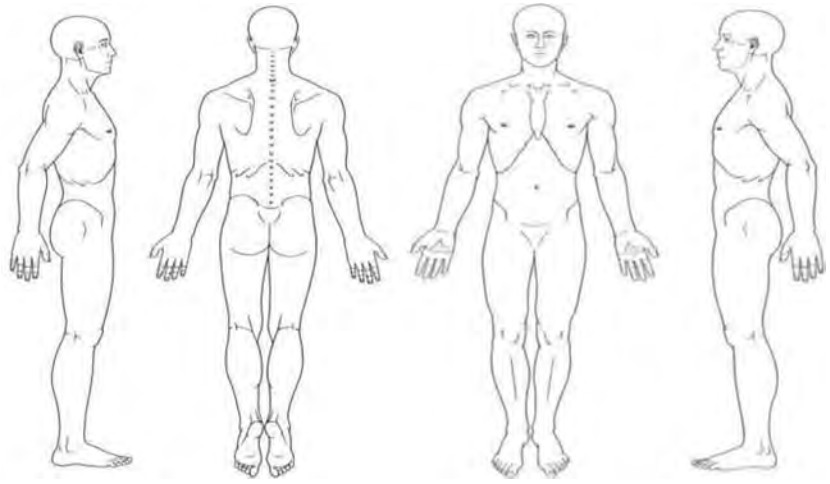
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____