CHOWCHILLA
Physical Therapy

PATIENT INFORMATION

DATE ______________________ PHONE # ( ) ____________________________

PATIENT NAME ____

ADDRESS____

CITY _______________________________________ STATE _______ ZIP CODE ____________________

SEX: F M BIRTHDATE: ______________ AGE _____ SOC. SECURITY # ______________________

EMPLOYER ____WORK PHONE _____________________

EMERGENCY CONTACT ____________________________________ PHONE ______________________

REFERRING MD ____ PHONE _________________________

INSURANCE INFORMATION

CONDITION RELATED TO: (circle one)

EMPLOYMENT MOTOR VEHICLE ACCIDENT PRIVATE INJURY OTHER

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE CO. ____ PHONE _____________________

INSURED'S NAME _________________________________ INSURED'S ID # _______________________

DATE OF INJURY _________________ CLAIM # ____

ADJUSTER ____________________________ PHONE __________________ FAX ___________________

PATIENT AGREEMENT

I, the undersigned, agree that the above information is true and correct and that all medical benefits, if any, are assigned and payable to Chowchilla Physical Therapy. I understand that I am financially responsible for all charges whether or not paid by insurance. (Workers Comp patients exempt from this statement.)

I hereby authorize the provider, Chowchilla Physical Therapy, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I hereby authorize Chowchilla Physical Therapy to release portions of my medical records including, but not limited to, insurance companies, health care providers, HCFA and/or its intermediaries.

Acknowledgement of Privacy Notice:

I have received a copy of the privacy notice or was informed of my privacy rights.

____ ____________________

Signature of Insured Patient / Guardian Date Signed

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PREVIOUS MEDICAL HISTORY

Have you had previous therapy for the diagnosis we are treating you for? ___YES ___ NO

If YES, where? ____

Have you ever had the following?

ARTHRITIS	YES ___	NO___	HERNIA	YES ___	NO___
DIABETES	YES ___	NO___	ALLERGIES	YES ___	NO___
HIGH BLOOD PRESSURE	YES ___	NO___	ALLERGIES TO HEAT OR ICE	YES ___	NO___
HEART ATTACK	YES ___	NO___	PREVIOUS SURGERIES	YES ___	NO___
PACEMAKER	YES ___	NO___	HEADACHES	YES ___	NO___
SEIZURES	YES ___	NO___	MIGRAINES	YES ___	NO___
METAL IMPLANTS	YES ___	NO___	CURRENTLY PREGNANT	YES ___	NO___
KIDNEY PROBLEMS	YES ___	NO___	OTHER ______________________		

IF YES to any of the above, please list with approximate date(s): ______________________________

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MEDICATIONS: Please list any medications you are currently taking: ___________________________

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Consent to Treat: I am aware of my diagnosis as given by my physician. I agree that the above information is true and correct. I have been informed of the treatment and care which has been prescribed by my physician(s) and will be provided by Chowchilla Physical Therapy.

I understand that as a patient I am under the care and control of my physician(s) and that Chowchilla Physical Therapy is not liable for any act or omission when providing treatment in accordance with my physician's instructions.

I acknowledge that no guarantee or assurance has been, nor can be, made by Chowchilla Physical Therapy as to the results of the prescribed treatment.

I acknowledge that pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Chowchilla Physical Therapy does not discriminate in the provision of services on the basis of race, color, national origin, disability, or age.

By signing this agreement, I consent to have Chowchilla Physical Therapy provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time.

Cancellation Policy: If you have to cancel or re-schedule, please notify us within 24 hours. Due to frequent cancellations and no-shows in our schedule, we now have a policy that if you cancel or not show for three or more appointments, it will result in scheduling your appointments on an "on-call" basis only. Please sign below that you acknowledge this policy.

Patient/Guardian Signature ______________________________ Date ____________________