Medical History Questionnaire

Last Name:_________________________First Name:_____________________M.I.:______Goes By: __________________________

Date of Birth:______/______/_______Sex designated on Insurance:___________Pronouns(he/she/they/other) _________________

Mailing Address:____

Phone:____________________________________Email Address: ____

Does our office have permission to leave a detailed message on your voicemail? ◯ **YES** ◯ **NO**

Allow mass emails for marketing purposes (i.e. exercise classes, etc.)**:** ◯ **YES** ◯ **NO**
(if NO, you will still receive emails regarding pertinent clinic information such as inclement weather closures)

I would like my billing statements emailed instead of sent through USPS mail: ◯ **YES** ◯ **NO**

I authorize automatic credit card charges for any statement balances and/or unpaid balances: ◯ **YES** ◯ **NO**
(if YES, please fill out the corresponding Credit Card Authorization form)

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Other Spouse/Partner Name: _______________________

Work Status: ◯ Employed ◯ FT Student ◯ PT Student ◯ N/A Employer: __________________________________

How did you hear about us? ____

I would like to receive appointment confirmations by: ◯ Email ◯ Text ◯ Both

Emergency Contact

Last Name:______________________________First Name:________________________Relationship:________________________

Phone:_________________________**Do we have permission to discuss medical information with them?** ◯ **Yes** ◯ **No**

Referring Provider:__________________________________Primary Care Physician: ____

What brings you in for physical therapy? ____

Have you had surgery for this ailment? ◯ Yes ◯ No Type(s) and Date(s) of Surgery: _________________________________

Have you had any of the following care for **THIS** injury/episode? **(please check all that apply)**

☐ Chiropractor	☐ Massage Therapy	☐ EMG/NCV	☐ Emergency Room Care	☐ CT Scan
☐ General Practitioner	☐ Neurologist	☐ MRI	☐ Podiatrist	☐ Myelogram
☐ Occupational Therapy	☐ Orthopedist	☐ X-Rays	☐ Naturopath	☐ Physical Therapy

Patient Goals: What do you expect to get from treatment? ______________________________

Have you had an injury due to a fall in the past year? ○ Yes ○ No Have you had 2+ falls in the last year? ○ Yes ○ No

Have you received physical, occupation, or speech therapy, or chiropractic services at any other office this injury? ○ Yes ○ No

Prescription and non-prescription medications, vitamins, or herbal medications

Name:____________________ Dose:__________ Frequency:__________ Reason: ______________

Name:____________________ Dose:__________ Frequency:__________ Reason: ______________

Name:____________________ Dose:__________ Frequency:__________ Reason: ______________

Date of last General Health Check-Up:__________ **Height:**__________ **Weight:** __________

Surgical/Trauma History: Please list type of surgery/trauma/accident, and month/year it occurred:

____

____

Do you now have, or have you ever had, any of the following? (C = Current, P = Past)

C	P	
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis/Swollen Joints
☐	☐	Asthma
☐	☐	Autoimmune Disorder
☐	☐	Cancer/Chemotherapy/ Radiation
☐	☐	Cardiac Conditions
☐	☐	Cardiac Pacemaker
☐	☐	Chemical Dependency
☐	☐	Circulation Problems
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Dizzy Spells/Fainting
☐	☐	Emphysema/Bronchitis
☐	☐	Fibromyalgia
☐	☐	Fractures
☐	☐	Gallbladder Problems
☐	☐	Frequent Headaches
☐	☐	Hearing Impairment
☐	☐	Hepatitis
☐	☐	High Cholesterol
☐	☐	High/Low Blood Pressure
☐	☐	HIV/AIDS

C	P	
☐	☐	Incontinence/Bowel Problems
☐	☐	Kidney Problems
☐	☐	Metal Implants
☐	☐	MRSA
☐	☐	Multiple Sclerosis
☐	☐	Muscular Disease
☐	☐	Osteoporosis
☐	☐	Parkinson's
☐	☐	Rheumatoid Arthritis
☐	☐	Seizures/Epilepsy
☐	☐	Do you smoke?
☐	☐	Speech Problems
☐	☐	Strokes/TIA
☐	☐	Thyroid Disease/Goiter
☐	☐	Tuberculosis
☐	☐	Vision problems
☐	☐	Hernia
☐	☐	Infectious Disease
☐	☐	Gout
☐	☐	Reiter's Syndrome
☐	☐	Sleeping Difficulty
☐	☐	Numbness or Tingling
☐	☐	Weakness
☐	☐	Weight Gain/Loss
☐	☐	Energy Loss

C	P	
☐	☐	Ehlers-Danlos Syndrome
☐	☐	Chronic Fatigue Syndrome
☐	☐	Head/Neck Injury
☐	☐	Back Injury
☐	☐	Shoulder Injury
☐	☐	Elbow Injury
☐	☐	Wrist/Hand Injury
☐	☐	Hip/Leg injury
☐	☐	Knee Injury
☐	☐	Ankle/Foot Injury
☐	☐	Recreational Drug Use
☐	☐	Mental Health Treatment
☐	☐	**Latex/Tape Sensitivity**

IF RELEVANT:

C	P	
☐	☐	Pelvic Inflammatory Disease
☐	☐	Irregular Menstrual Cycle
☐	☐	Endometriosis

#________Complicated Pregnancies

#________Complicated Deliveries

#________C-Section Deliveries

#________Vaginal Deliveries

○ Yes ○ No **Are you Pregnant?**

Please list any other conditions you have, or have ever had that are not listed above that you feel could be important to your care:

____

____

Patient/Guardian Signature:____ **Date:** ____________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING __*0*__ **+** ______ **+** ______ **+** ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Cancellation, No Show and Late Arrival Policy

Reminder Texts and emails are provided as a courtesy. A no show or late cancel fee will still be applied if you did not get a reminder. *Ultimately it is your responsibility to know when your appointments are scheduled.*

Cancellation due to COVID symptoms or a positive COVID test: Following current health guidelines, cancellation due to COVID-like symptoms or a positive COVID test will require the cancellation of all appointments that are scheduled within 10 days of the start of symptoms.

Late cancellations:

24-hour notice is required to cancel or reschedule a one-hour appointment. Two-hour appointments require 48-hour notice. **EXCEPTION**: Monday appointments must be cancelled prior to the weekend. Voicemails left over the weekend for a Monday appointment will be counted as a late cancellation.

We understand that illnesses and family emergencies can arrive suddenly. Please notify us as soon as possible if you will be unable to make your scheduled appointment. **The first late cancellation fee per year, due to contagious illness or family emergency will be waived. Late cancellation number 2 and 3, regardless of reason, will incur a fee of $50.** Any subsequent late cancellations or no-shows will be charged the full self-pay appointment rate of $90.

No Shows:

If there is no prior communication given that you will not be able to attend your appointment, a no-show fee will be assessed. The first occurrence will incur a **$60 fee** and any subsequent occurrences will be charged the full self-pay appointment rate of $90.

Late Arrivals:

Depending on what time you arrive, you could be assessed a $15-$30 fee for a one-hour appointment. Arriving late to a two-hour appointment could result in a $15-$125 fee.

***** Late cancellation, no show and late arrival fees will not be covered by insurance *****

Signature____**Date**________________

Agreement To Pay

I understand and agree that I am responsible and liable for payment of all charges assessed for professional serviced rendered. I understand insurance claims will be submitted to my insurance company as a matter of convenience to me and I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance forwards payment directly to me, I will deliver such payment to CS Physical Therapy.

Signature____**Date**___________________________

☐ **Forward me the bill** ☐ **Charge my card below**

Credit Card Authorization

I authorize CS Physical Therapy to automatically charge my credit card for any outstanding balance on my account **after claims are submitted and processed by my insurance,** beginning from the date signed below. Balances may include:

- Co-pays
- Deductibles
- Supplies Purchased
- Any unpaid balance

I agree to allow CS Physical Therapy to charge the personal credit card provided upon receipt of my insurance EOB or if there is an outstanding balance on my account or another client's account as designated below.

Patient Name ____

Cardholder Name ____

Credit Card Number ____

Expiration Date ___________________________ **CVV Code** ___________________________

Billing Zip Code associated with Credit Card ____

Cardholder Signature____**Date** _______________

Informed Consent and Privacy Policy

What is Physical Therapy? Physical therapy is a rehabilitation method that helps patients gain or regain the physical activities that they lost or that they are incapable of doing due to defects either from birth or resulting from injuries or disease. There are various methods of treatments to help one to regain and/or improve his or her physical function.

How Physical Therapy is Performed: Physical therapy is often done with the help of guided exercises. Some use additional agents such as heat or cold compress, sound waves, electricity, or mechanical devices or machine. This will depend on the issues that are needed to be addressed and the technology available for the physical therapist to utilize.

The Risks: As physical therapy intends to resolve the problem that the person is experiencing due to illness or injury, there are some risks that may arise during the course of the treatment such as pain and discomfort during the process of therapy. Stretching and twisting may cause some swelling and soreness of stiff muscles. This is normal. There are therapies that may use hot or cold compresses in order to relieve the pain during therapy. Your physician may recommend drugs in order to help you with your pain and swelling while going through the process of physical therapy.

Please take note that some can experience pain and discomfort that may reduce one's motivation to continue due to pain or lack of obvious results. It is important that the person continues with the therapy if it is too early to see the results. It would be best to discuss these matters with your physical therapist.

Expectations: There are not guaranteed expectations when one undergoes physical therapy treatment. This depends on the situation. But when one undergoes a physical therapy program, it is intended that one will be able to return to his or her prior level of functioning or develop a method to continue what was possible to be performed before the injury. When going through the program, it is important that the patient is truthful with what he or she thinks or feels. Good communication is important for the progress of the patient.

I have read and understand the information given to me and the consent to my treatment for physical therapy.

Signature ____ **Date**______________

Our legal duty: We are required by law to protect the privacy of your personal health information and will only use that information in order to treat you or assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

Disclosures not requiring your authorization: in the following circumstances, we may disclose your health information without your written consent: for purposes of public health and safety, to government agencies for purposes of their audits, investigations and other oversight activities, or when required by court orders, search warrants, subpoenas, and as otherwise required by law.

Your individual rights: As our patient, you have the following rights: to have access to and/or a copy of your health information, to receive an accounting of certain disclosures we have made of your health information, to request restrictions as to how your health information is used or disclosed, to request that we communicate with you in confidence, to request that we amend your health information, to receive notice of our privacy practices.

Concerns and complaints: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer, Craig Shiraishi at 408-246-5861. If you are still concerned after talking with our Privacy Officer, you may file a written complaint with the Department of Health and Human Services

Payment Policy and Consent to Treat

X________
Initials

Billing: I have reviewed the billing section and agree for CS Physical Therapy to submit my information to my insurance.

- Benefits will be checked prior to your appointment. This does not guarantee payment from your insurance and ultimately you are responsible for payment.
- Initial Evaluation cost is approximately $150.
- Follow up appointments cost approximately $80.

Private Pay:

- Appointments are scheduled for 1 hour.
- Private pay rate is $150.00 for the Initial Evaluation and $80 for Follow up appointments.
- We are unable to offer this rate and bill insurance during the same episode of care, unless benefits have been exhausted.
- Superbills with CPT codes to submit to insurance are not available for private pay appointments.

X________
Initials

Assignment of Benefits/Authorization to Release Medical Information, Consent to Treatment: I hereby assign all medical benefits to which I am entitled to ________________________ in the event they file insurance on my behalf. I understand that I am financially responsible for all charges regardless of payment from my insurance. If my account becomes delinquent (over 90 days past due) and is therein default, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees of $20.00 per balance transferred, attorney's fee, and all court costs including additional legal fees associated with the recovery of this debt. All balances must be paid off within one year from the first date of service. I understand that there is a fee for all returned checks as allowed by state law. I hereby authorize said assignee to release all information necessary to secure payment of said benefits, and I do hereby consent to such treatment by the authorized personnel of CS Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment exception acts of negligence.

X________
Initials

Privacy Practices: A copy of HIPAA policy & procedures and Red Flag Rules have been provided and I have read and fully understand.

X________
Initials

Cancellation/No Show/Late Arrival Policy: Cancellation of a one-hour appointment requires 24-hour prior notice. If an appointment is on a Monday, cancellation notice must be given on the Friday prior. Please see our full posted Cancellation, No Show, and Late Arrival Policy that includes associated fees. A copy of the policy for your records has been provided.

Patient Name____ **Date of Birth**____________________

Signature____ **Date**_________________________

Parent/Guardian Name________________________________ **Relationship:** ____________________
(if applicable)