NEW PATIENT INFO. & MEDICAL HX-PI

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

Have you ever had physical therapy before? (YES / NO) If yes, when was your last treatment? _____

What are your health goals? (Check one of the following)

( ) Reduce symptoms only ( ) Reduce symptoms and show me how to prevent flair-ups ( ) Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance_____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

MEDICAL HISTORY

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

*****ARE YOU PREGNANT? (YES / NO)*****

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Name of your family physician _____Last appointment with your physician _____Phone # _____Fax # _____
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
Please list any surgeries you have had and when.
_____
Please list any medications you are taking.
_____

PATIENT SIGNATURE _____ **DATE** _____

NEW PATIENT COMPLAINT(S)

Name _____ (Complete #1-10) Date _____

1. What is your **worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **second worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

3. Briefly describe any other complaints. _____

_____

4. How much have these symptoms interfered with the following activities? (check all that apply)

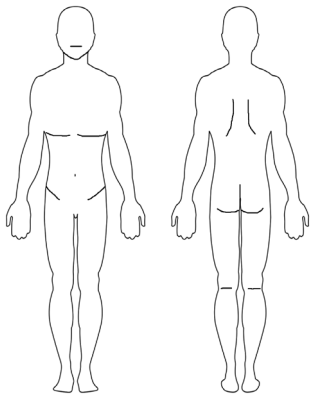
Work	Social Activities
___ Not at all	___ Not at all
___ A little bit	___ A little bit
___ Moderately	___ Moderately
___ Quite a bit	___ Quite a bit
___ Extremely	___ Extremely

5. Circle any other symptoms you are experiencing.

(Sharp Pain) (Dull Ache) (Shooting Pain) (Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX **Numbness OOO** **Tingling √ √ √**
Stiffness / / / **Burning + + +**



7. Who have you seen for your symptoms?(check) ___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other

a. What treatment did you receive and when? _____

b. Circle any tests have you had for your symptoms? (X-Rays) date:____ (CT Scan) date:_____ (MRI) date:_____ (Other)

8. Have you had similar symptoms in the past? (YES / NO)

If yes, when was the last time you experienced those symptoms? _____ How long did your symptoms last? _____

9. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

10. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed? (Circle all that apply)

Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Seizures

DOCTORS NOTES: _____

_____

First Serve Physical Therapy, PC—330 Rancheros Dr Suite 202, San Marcos, CA 92069—Ph/ Fax:760.630.8060

First Serve Physical Therapy, PC
330 Rancheros Drive Suite 202
San Marcos, CA 92069

Consent for treatment: I, as a patient, consent to physical therapy at First Serve Physical Therapy, PC as prescribed by my referring provider. I consent to maintain the confidentiality of other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than myself.

Initials: _____

Authorized Release of Information: I hereby authorize First Serve Physical Therapy, PC to release medical records pertaining to my treatment to any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to First Serve Physical Therapy, PC. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Initials: _____

HIPPA Patient Information Consent: I understand that First Serve Physical Therapy, PC 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 I have the right to restrict how my personal health information I used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand First Serve Physical Therapy, PC will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: _____

Signature: _____ Date: _____

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged an interest of up to 15% per annum based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you may be charged a $50 fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received or had the opportunity to view our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE FOR PROVIDERS

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

SECTION 1785.27 CIVIL CODE

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

CURRENT CUSTOMARY FEE SCHEDULE / TIME OF SERVICE DISCOUNT / WAIVER OF NO SURPRISE ACT

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. According to (California Business and Professions Code 657), we offer a Pay at Time of Service Discount (TOS) which you may qualify for. All fees listed below may change without notice. Waiver of No Surprise Act: With my signature I am saying I agree to get any services listed below and am consenting of my own free will and not being coerced or pressured that I am giving up some consumer billing protections under federal law. I may get a bill for the full charges for these services or have to pay out-of-cost sharing under my health plan. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit. I can end this agreement by notifying the provider or facility in writing before getting services.

Initial Exam	99202	Expanded	$150.00	**Re-Exam**	99211	Minimal	$50.00
(New Patient)	99203	Detailed	$250.00	*(Established Patient)*	99212	Limited	$125.00
	99204	Comprehensive	$375.00	*(Treated within 3 years)*	99213	Expanded	$175.00
	99417	Prolonged Eval	$200.00		99214	Detailed	$250.00

Manual Therapies:	97140- $60.00	**Neuromuscular Re-Ed:**	97112- $70.00
Therapeutic Exercises:	97110- $75.00	**Therapeutic Activities**	97530- $80.00

Consent to treat a minor: I _____ the parent or legal guarding, who has permission to make medical decisions for _____, a minor child, authorize any necessary treatment at First Serve Physical Therapy PC for my minor child and fully agree to the above terms.

PRINT NAME	SIGNATURE	DATE

First Serve Physical Therapy, PC

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **First Serve Physical Therapy, PC .**

I understand that the Notice describes the uses and disclosures of my protected health information by **First Serve Physical Therapy, PC** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name

Today's Date

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SECTION 1785.27 CIVIL CODE

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

MEDICAL LIEN AGREEMENT

PATIENT NAME: _____ DATE OF INJURY/INCIDENT: _____

PROVIDER NAME: _____

ATTORNEY NAME: _____ LAW FIRM NAME: _____

Patient ("Patient") desires medical treatment by Provider, including all entities and specialists that provide services for, at or through Provider (collectively, "Provider") for injuries sustained in a personal injury incident ("Incident"). Patient has or shall retain Attorney ("Attorney") to seek compensation ("Litigation"). At Patient's request, Provider agrees to treat Patient on a "lien" basis ("Medical Lien"), establishing a debtor-creditor contractual relationship, whereby Patient remains responsible to pay Provider's bill ("Bill"), but Provider agrees wait to be paid until the conclusion of the Litigation. However, if any provision of this Medical Lien is not strictly complied with by Patient or Attorney, Provider may declare a breach of this Medical Lien agreement, and Patient agrees to then pay the full balance owed Provider immediately; and, if Patient fails to timely pay, Provider may immediately file a lawsuit for the monies owed plus any other claims and/or entitlements based upon the number, type and extent of the breach(es) involved. The following terms and conditions apply:

1. Provider's Medical Lien is against all payments arising from the Incident, including but not limited to, settlement proceeds, "med pay", or payment of a judgment arising from the Litigation ("Proceeds").
2. Patient and Attorney acknowledge that even if Attorney drops Patient in the Lawsuit, or, the Litigation results in no recovery, Patient must still pay Provider the full Bill amount regardless of the Litigation outcome. Patient and Attorney further acknowledge there is no requirement that Provider discount the Bill.
3. Provider considers lien reduction requests on a case-by-case basis, provided Patient and Attorney are timely, fully cooperative, and provide all information requested by Provider. Any reduction on Patient's Bill must be agreed to by Provider in writing. Bill reduction requests should be made prior to any Lawsuit settlement, so that Patient knows if, and the extent, Provider is willing to reduce the Bill.
4. All Bill reductions are contingent upon Provider receiving the agreed payment within 10 calendar days of receipt by Attorney or Patient of any Proceeds, or within sixty 60 calendar days from the date of Provider's signed reduction agreement, whichever occurs first (even if no expiration period is stated in the Bill reduction letter or agreement). If payment is not timely received by Provider, the prior Bill reduction agreement is rendered null and void, and the full Bill is due and owing (and Attorney or Patient will need to make a new reduction request which Provider is not obligated to accept).
5. Any modification of this Medical Lien not initialed by Provider in writing, will result in the original non-modified Medical Lien as originally presented by Provider (prior to any attempted changes) being the binding Medical Lien, without the modifying language.
6. All "med pay" arising from the Incident is expressly and permanently assigned by Patient to Provider and will be immediately paid to Provider if received by Attorney or Patient. Med pay received will reduce the outstanding Bill by the amount of the "med pay" received by Provider.
7. Any sums owing to Provider shall accrue interest at the rate of ten percent (10%) per annum from the date of treatment until the outstanding balance is fully paid ("the full Bill"). Provider is also entitled to any consequential damages incurred (e.g., costs of third party collection services, administrative fees/costs to address matter with Attorney and/or Patient). The prevailing party in any action to enforce this Medical Lien shall be entitled to their reasonable attorney's fees and costs. Venue for any disputes arising under this Medical Lien shall be in the county where Provider is located. If Patient is or becomes unrepresented by an attorney or brings a Small Claims action rather than a Lawsuit in Municipal or Superior Court, then Provider may declare a breach of this Medical Lien. Attorney and Patient shall keep Provider or Provider's agent updated on the Lawsuit status, communicate timely the date of filing of a Complaint, setting or moving of trial/arbitration/mediation, filing a Small Claims action, any change in Patient's representation or if co-counsel brought in to try the matter (co-counsel to be bound by this same Medical Lien). Best efforts shall be used, and time is of the essence, for all performances under this Medical Lien. This Medical Lien may be sold, transferred or assigned by Provider to a third party.

ALL THE ABOVE IS AGREED TO:

PATIENT (SIGN): _____ DATE: _____

ATTORNEY (SIGN): _____ DATE: _____

PROVIDER (SIGN): _____ DATE: _____

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AUTHORIZATION FOR RELEASE OF RECORDS FROM:

_____

_____

_____

_____

_____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

Drew Mason , DPT
First Serve Physical Therapy, PC
330 Rancheros Dr. Suite 202
San Marcos, CA 92069
PH/ Fax: 760-630-0683

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):_____ TO _____

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: _____

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

PATIENT'S DATE OF BIRTH: _____

DOCTOR'S SIGNATURE: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name _____
Claim/Group#_____
SS#/ID#_____

I hereby instruct and direct the _____ Insurance Company to pay by check made out to and mailed directly to:

First Serve Physical Therapy.
330 Rancheros Dr Suite 202
San Marcos, CA 92069

for professional or medical expense benefits allowable under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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

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

Date _____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

First Serve Physical
Therapy, PC
Office: 760.630.0683

Auto Insurance Information

Patient Name: _____
Date of Birth: _____

Your Auto Insurance Company

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Third Party Insurance Company (other driver)

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Attorney Information

Name of Attorney: _____
Phone Number: _____
Fax: _____