Todd Martin PT Jared Bailey PT Samantha Stollberg PT, GCS
Tom Meenzhuber PT John Hollinshead PT, OCS John Hinds PT
Karen Bailey PT Adrian Asencio OT R/L, CHT

PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM

NAME: _____ Male/Female Date: _____

Address: _____
Street City State Zip

Phone: Home- _____ Cell: _____

Social Security Number: _____ Birthdate: _____ Age: _____

Do you want to be e-billed? **Y N** Email address: _____

Emergency Contact Person: _____ _____ _____
Not living with patient Name Relationship Phone

Name of Parent or Spouse: _____

Language of preference: English/Spanish/Other _____

Responsible Party/Parent/Guardian Name: _____

Phone: Home-_____Cell:_____Work: _____

Address:_____
Street City State Zip

EMPLOYMENT

Employer: _____ Job title: _____

Address: _____ Phone: _____ Ext: _____

Can we call you at work if necessary? Y N Are you currently working? Y N

Parent/spouse employer:_____

INSURANCE INFORMATION

TYPE: Private _____ Medicare _____ Worker's Comp _____ Other _____
Specify

PHYSICIAN

Primary Care Physician: _____Referred by:_____

Date of injury/surgery:_____ Date of next doctor visit?_____

Any previous PT for current problem? Yes No What was done/what was outcome? _____

Any chiropractic treatment? Y N Number of visits: _____ Any other form of treatment: _____

Any previous injury to this area? Y N Was this a work related injury? Y N Is case open/closed?

Have you had Physical or Speech Therapy this year? Y N With Whom: _____ Have you had or are you having Home Health? Y N If yes with whom: _____

What was Home Health discharge date?: _____

HISTORY

Do you have/or have you had any of the following:

High Blood Pressure (reading ___/___)	Yes No	Sensitive to ice/heat	Yes No
Heart Disease	Yes No	Allergies	Yes No
Heart Attack	Yes No	Hernia	Yes No
Pacemaker	Yes No	Seizures	Yes No
Stroke	Yes No	Diabetes	Yes No
Metal Implants	Yes No	Headaches	Yes No
Dizziness/vertigo	Yes No	Nervous/Psychological Disorder	Yes No
Hearing Problems	Yes No	Incontinence	Yes No
Asthma/Respiratory Problems	Yes No	Neurological Disorder	Yes No
Tuberculosis (Year _____)	Yes No	Osteoarthritis/Osteoporosis	Yes No
Currently pregnant _____months	Yes No	Smoker	Yes No
Active Infections _____	Yes No	AIDS	Yes No
Cancer	Yes No	Hepatitis A/B/C	Yes No

Other: _____

If yes to any of the above please explain & give approximate date:

_____

Past surgeries: _____

_____

What is your occupation & physical requirements of job: _____

_____

Do you have difficulty with any of the following activities? (Check all that apply & specify distance, time, etc limits)

Standing _____ Sleeping _____ Sitting _____

Walking _____ Driving _____ Lifting _____

Personal Care _____ Other _____

What benefits do you expect to gain from physical therapy? _____

_____

The above information is correct to the best of my knowledge.

I have read and fully understand Santa Maria Valley Physical Therapy Group (SMVPT) Notice of Information Practices. I understand that SMVPT 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 SMVPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in SMVPT Notice of Information Practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing at any time.

I hereby authorize my insurance company to pay directly to SMVPT medical benefits otherwise payable to me. I understand that I am responsible for all charges regardless of insurance coverage.

I authorize SMVPT to contact former providers of physical therapy for information regarding Medicare payments pertaining to the Medicare cap.

Signature: _____ Date: _____

SHORT-FORM McGILL PAIN QUESTIONNAIRE

Patient name: _____ Date: _____

	None	Mild	Moderate	Severe
Throbbing	(0) _____	(1)_____	(2) _____	(3) _____
Shooting	(0) _____	(1)_____	(2) _____	(3) _____
Stabbing	(0) _____	(1)_____	(2) _____	(3) _____
Sharp	(0) _____	(1)_____	(2) _____	(3) _____
Cramping	(0) _____	(1)_____	(2) _____	(3) _____
Gnawing	(0) _____	(1)_____	(2) _____	(3) _____
Hot-Burning	(0) _____	(1)_____	(2) _____	(3) _____
Aching	(0) _____	(1)_____	(2) _____	(3) _____
Heavy	(0) _____	(1)_____	(2) _____	(3) _____
Tender	(0) _____	(1)_____	(2) _____	(3) _____
Splitting	(0) _____	(1)_____	(2) _____	(3) _____
Tiring-Exhausting	(0) _____	(1)_____	(2) _____	(3) _____
Sickening	(0) _____	(1)_____	(2) _____	(3) _____
Fearful	(0) _____	(1)_____	(2) _____	(3) _____
Punishing-cruel	(0) _____	(1) _____	(2) _____	(3) _____

A. Please make an "X" on the line below to show how bad your pain is right now.

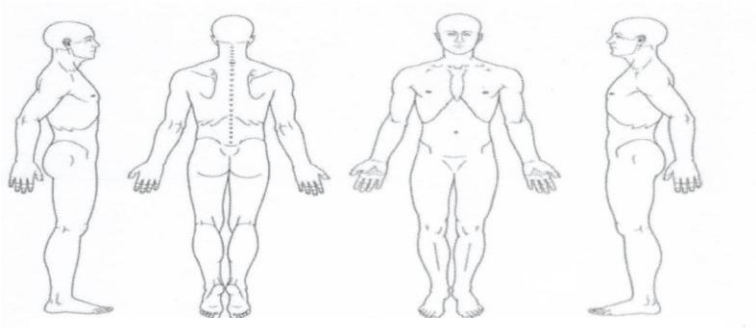
No pain |----------| Worst possible pain

B. Please check the one descriptor that best describes your present pain.

0 No pain _____
1 Mild _____
2 Discomforting _____
3 Distressing _____
4 Horrible _____
5 Excruciating _____

C. Is your pain? (check one word) Brief _____ Intermittent _____ Continuous _____

Please indicate location of pain:



S=___/33 A=__/12

Medical Release Form

If you have had medical testing (X-rays, MRI, etc.) or surgery related to the current diagnosis, please PRINT your name below so that we may review these reports.

Patient Name: _____

Date of Birth: _____

Place of service: _____

You are hereby authorized to release to Santa Maria Valley Physical Therapy Group the report(s) requested below.

_____ _____

Signature Date

Report requested: _____

_____

_____

DATE OF SERVICE: _____

Please fax the requested report(s) to (805) 349-7206 or mail to Santa Maria Valley Physical Therapy Group
820 East Enos Drive, Santa Maria, CA 93454

Santa Maria Valley Physical Therapy Group Inc.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Patient Signature: _____

Date: _____

Santa Maria Valley
PHYSICAL THERAPY GROUP

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CREDIT CARD PRE AUTHORIZATION FORM

I authorize **SANTA MARIA VALLEY PHYSICAL THERAPY GROUP** to keep on file and to charge my debit/credit card for any services provided to _____ as specified below.

Please initial each line showing you have read and understand.

____ Fees for services not paid by guardian, patient, or patients insurance within 90 days.

____ Co-pays not paid at the time service was rendered.

____ Balance of any charges that were not covered by patients insurance.

Name of patient: _____

We will bill your insurance as a courtesy to you, however, you are responsible for the total payment regardless of any denial or partial insurance payments.

Terms of Agreement: Santa Maria Valley PT Group reserves the right to refuse or terminate your automatic credit card payment services. This agreement is to remain in effect until Santa Maria Valley Physical Therapy Group terminates it or receives written notification of its termination and has sufficient time to act on it.

Patient Name: _____

Cardholders Name (as it appears on card: _____

Cardholders Billing Address: _____

_____

☐ Visa ☐ Mastercard ☐American Express ☐ Discover Card

Credit Card Number: _____

Expiration Date: _____ CV#: _____

PLEASE LIST ALL MEDICATIONS TAKEN TO INCLUDE PRESCRIPTION, HERBAL SUPPLEMENTS, VITAMINS

PATIENT NAME: DATE:

☐ **I do not wish to participate in this form**

NAME OF MEDICATION	DOSAGE	FREQUENCY TAKEN	ROUTE TAKEN (Oral, IV, etc)
Example: Celebrex	*25 mg*	*once daily*	*oral*