



5120 Manzanita Ave Ste 110
Carmichael, CA 95608
Phone: (916) 926-0496
Fax: (916) 248-7477

PATIENT INFORMATION FORM

Please complete ALL fields. If a field does not apply, put N/A

Patient Name: _____ DOB: _____
Last First Middle

Address: _____
Street City State Zip

Primary Phone: _____ Secondary Phone: _____

Appointment reminder preference: ☐ Text ☐ Call ☐ None

Gender: ☐ Male ☐ Female Marital Status: _____ Social Security #: _____

Email Address: _____

Person to notify in case of EMERGENCY:

Name: _____ Phone: _____ Relationship: _____

Medical History:

Have you been treated here or by another physical therapist previously? ☐ Yes ☐ No

If yes, where: _____ When: _____

Was it for the same condition? ☐ Yes ☐ No

HAVE YOU RECENTLY RECEIVED ANY TYPE OF HOME HEALTH? ☐ Yes ☐ No

If yes, name of home health agency: _____

**If you have not been formally released from home health OR are currently receiving home health, please be aware that insurance will not cover both services*

Insurance Information:

Primary Insurance Plan: _____

Is there a secondary insurance plan? ☐ Yes, enter details below ☐ No

Secondary Insurance Plan: _____

Secondary Plan ID #: _____ Policy Holder's Name: _____

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ Yes ↓ ☐ No

Adjuster's Name: _____ Ph # _____

IS THIS AN ACCIDENT CASE? ☐ Yes ↓ ☐ No

Attorney's Office/Representative: _____

Ph # _____ Fax # _____ Email: _____

Acct # _____

HEALTH HISTORY

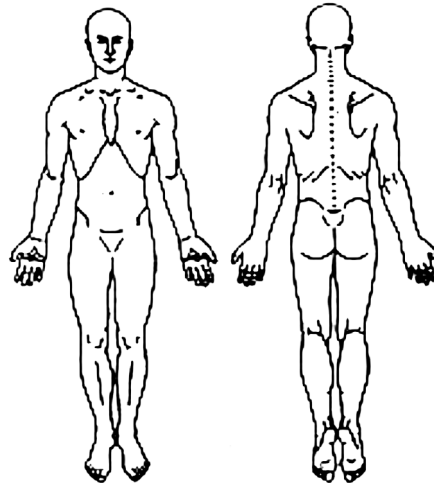
Name:		DOB:	Age:	Gender:
Height:	Weight:	Occupation:	Injury Date:	

1. Do you have any of the following medical conditions (check all that apply)?

- | | | | |
|--|--|---|---|
| ☐ Heart Problems | ☐ Headaches | ☐ Recent fractures | ☐ Major surgery |
| ☐ Pacemaker/Afib | ☐ Infection | ☐ Serious injury | ☐ Medical allergies |
| ☐ High Blood Pressure | ☐ Asthma | ☐ Epilepsy | ☐ Numbness/tingling in arms/legs |
| ☐ History of Stroke | ☐ Diabetes | ☐ Cancer | |
| ☐ Pregnancy | ☐ Other (please specify): _____ | | |

0	1-2	3-4	5	6	7-8	9-10
No pain	Mild pain	Discomforting pain, may be ignored	Discomforting pain, may be distracted	Distressing pain, but able to perform tasks	Intolerable pain. Concentration is difficult, but able to perform some tasks	Intolerable pain, hospital care is required

2. Please rate your pain on the scale above ↑. Circle the location of your pain on the diagram below ↓



3. How did the injury occur? (Please be specific) _____

4. Did you have surgery for this injury (if yes, what type and the date of surgery)? _____

5. Is your pain getting better? _____ worse? _____ same? _____

6. Have you already received treatment for this problem from other providers (check all that apply)?

- ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other: _____

7. What test(s) or treatment(s) have you had concerning this problem (check all that apply)?

- ☐ X-ray ☐ CT Scan ☐ MRI ☐ EMG ☐ Myelogram
☐ Cortisone Injections ☐ Biofeedback ☐ Other: _____

Appointment Cancellation & No-Show Policy

To make sure every patient has fair access to appointments, our clinic follows the attendance policy below.

Please read, initial each box, and sign below to confirm you understand our clinic's attendance policy.

Cancellations & Rescheduling

☐

If I need to cancel or reschedule my appointment, I will call the clinic at **(916) 926-0496** at least **24 hours** before my scheduled appointment time.

☐

I understand I may be charged a **\$75.00 fee** for a no-show, or for canceling/rescheduling with less than 24 hours' notice.

☐

I understand that **any** cancelled or rescheduled appointment counts as a cancellation on my account.

☐

I understand that **3 cancellations/reschedules** may result in being dismissed from physical therapy, or being moved to a same-day/standby schedule, at the clinic's discretion.

No-Shows

☐

A **no-show** means missing an appointment without calling or notifying the clinic. If I no-show, the clinic may cancel any other appointments I have scheduled.

☐

I understand that **2 no-shows** may result in being dismissed from physical therapy, or being moved to a same-day/standby schedule, at the clinic's discretion.

Late Arrivals

☐

Arriving **any time after** my scheduled appointment time counts as a late arrival. If I am late, the clinic may need to reschedule my visit, which will then count as a cancellation.

Please note: Both short-notice cancellations and repeated cancellations (even with more than 24 hours' notice) can affect your ability to stay on the schedule. Frequent cancellations limit treatment consistency and reduce appointment availability for other patients.

Non-Compliance

Your adherence to the recommended treatment sessions is a vital component of your progress in physical therapy. Repeat instances of non-compliance with your scheduled visits will result in the discontinuation of physical therapy and we will inform your referring provider that you were dismissed due to non-compliance with the prescribed rehabilitation order.

I have read and understood this policy, and I agree to follow it.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

INFORMED CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of therapeutic procedures, to aid the patient in achieving their maximum potential within their capabilities and accelerate convalescence and reduce the length of functional recovery. (Therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, e-stim, and ultrasound; and special procedures such as taping.) All procedures will be thoroughly explained to you before you are asked to perform them. Individuals will be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religion, age, sexual orientation, or sources of payment for care.

Response to physical therapy intervention varies from person to person so it is not possible to predict your response to a specific modality, procedure, or exercise protocol. Spring Physical Therapy cannot and does not guarantee what your reaction will be to a specific treatment. Potential benefits of treatment may include an improvement in symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in movements and a decrease in pain or discomfort. However, there are potential risks that the physical therapy treatment may cause: you may experience an increase in your current level of pain, or discomfort or result in aggravation of existing systems, pain, or injury. It is very important for you to promptly provide any updates about your medical condition(s) and to communicate with your treating physical therapist throughout your treatment.

You may decline any part of your treatment at any time before or during treatment if you feel any discomfort or pain or have any other unresolved concerns. You may ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results, and you may discuss potential risks and benefits involved in your treatment. The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. You understand that the physical therapist provides a wide range of services and you will receive information at the initial visit concerning the proposed treatment and options available for your condition.

By signing below, I have read this consent form and understand the risks involved with physical therapy care treatment. I voluntarily assume all of the foregoing risks and accept full responsibility for any loss, property damage, illness or exposure to illness, or personal injury, that may be sustained by me or my property as a result of my receiving such physical therapy care and treatment. I hereby give consent for Spring Physical Therapy to furnish such care and treatment considered necessary and proper in treating my physical condition.

I certify that I have read and understand the above consent statements:

Patient's Signature: _____ **Date:** _____

Parent or Authorized Representative (if applicable): _____

FINANCIAL POLICY

I hereby agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Spring Physical Therapy (SPT). I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, AUTO, ETC.), then I am financially responsible and agree to pay for all the charges related to services provided to the patient at SPT. In the event that services deemed medically necessary by my physical therapist are not covered, not authorized or deemed not medically necessary by my Health Plan, then I, the member, will be held financially responsible and agree to pay for all the charges related to the services provided by SPT.

Although I have requested Spring Physical Therapy to bill my insurance company on my behalf, I clearly understand that I am responsible to SPT for payment on my account regardless of the status of my insurance claim.

I hereby authorize Spring Physical Therapy to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

To ensure you receive the best quality care, staff at Spring Physical Therapy must speak with other medical professionals and/or personal contacts involved in your care. If there are any other individuals who may be involved in your care that you would like Spring Physical Therapy to be able to communicate with, please list those individuals below:

Examples include family, friends, caregivers, secretaries, transportation company etc.

1) _____

2) _____

3) _____