NAME:

Patient Medical History

Please circle yes or no:

Diabetes . . . . . yes no
High Blood Pressure. . . . . yes no
Heart Disease. . . . . yes no
Heart Attack (Myocardial Infarction) . yes no
Previous Surgery. . . . . .yes no
Pacemaker. . . . . yes no
Cancer. . . . . .yes no
Metal Implants. . . . . .yes no
Valvular Disease. . . . . yes no
Arrhythmia . . . . . .yes no
Angioplasty . . . . . .yes no

Sensitivity to Heat . . . . . .yes no
Sensitivity to Ice . . . . . yes no
Allergies . . . . . yes no
Headaches . . . . . yes no
Seizures . . . . . yes no
Hernia . . . . . .yes no
Kidney Problems . . . . . yes no
Stents, Artery Bypass . . . . . .yes no
Coronary Artery bypass Graft: . . . . . yes no
Osteoporosis . . . . . yes no
Pregnant . . . . . .yes no maybe

Lungs:

Chronic Obstructive Pulmonary Disease (COPD) . . . . . yes no
Emphysema . . . . . yes no
Chronic Bronchitis . . . . . .yes no
Asthma . . . . . yes no
Recent pneumonia . . . . . yes no

Vascular:

Peripheral Arterial Disease . . . . . .yes no
Taking Blood Pressure Meds . . . . . .yes no
Acquired Respiratory Distress Syndrome (ARDS) . . . . . yes no

Stroke/TIA . . . . . yes no
Atherosclerotic Disease . . . . . yes no

General Medical Conditions:

Arthritis (Rheumatoid/Osteoarthritis) . . . . . yes no
Bladder, Prostate or Urination Problems . . . yes no
Hearing Impairment . . . . . yes no
(very hard of hearing with hearing aids)
Gastrointestinal Disease . . . . . yes no
(Ulcers, Hernia, Reflux, Bowel, Liver, Gall Bladder)
Visual Impairment . . . . . yes no
(such as Cataracts, Glaucoma, Macular Degeneration)
Back Pain . . . . . .yes no
(Neck Pain, Low Back Pain, Degenerative Disc Disease, Spinal Stenosis)

Anxiety or Panic Disorder . . .yes no
Depression . . . . . yes no
Incontinence . . . . . .yes no
Sleepy Dysfunction . . . . . .yes no
Smoker . . . . . .yes no
(# of packs/Day)___
Alcohol/Drug Addiction . . . . .yes no
Prosthesis/Implants . . . . . yes no
Neurological Disease. . . . . .yes no
(such as MS or Parkinson's)

Pain level at this moment: 0 1 2 3 4 5 6 7 8 9 10
Please list any medications being taken:_____
_____
Other Disorders:_____

3.5.1C PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

California Rehabilitation & Sports Therapy
200 Newport Center Dr., Suite 213
Newport Beach, CA 92660

(Clinic Name)

I have read and understand the HIPAA privacy notice 3.5.1A. I understand that upon request a copy of the complete notice will be provided to me.

Patient Name (Print)

Patient Signature

Date

CAL REHAB & SPORTS THERAPY POLICIES AND PROCEDURES

Insurance Verification & Billing:

The support staff of Cal Rehab will bill your insurance company once you have provided us with a completed intake sheet and copy of your insurance card. Verification of eligibility and benefits for physical therapy is provided as a ***Courtesy*** to you. **You are ultimately responsible for the knowledge and understanding of the benefits provided to you by your insurance plan. You are also responsible for the prompt and full payment for all services provided.**

Office co-payments and/or contributions toward annual deductibles are due at time of service. Contributions to annual deductible are ***PARTIAL PAYMENTS ONLY.*** *You will receive a bill for the remaining balance.*

Patient Attendance Contract:

We agree to work with you in accommodating your therapy scheduling. In return, we appreciate your courtesy regarding timely arrival for your therapy appointments. Being late may result in your appointment being rescheduled due to lack of time for a productive treatment. We also request that you provide twenty-four hour notice for cancellations. Cancellations with less than twenty-four hour notice and "No Shows" may be subject to a **$25.00** cancellation fee.

I HAVE READ THE ABOVE POLICIES AND PROCEDURES AND UNDERSTAND MY RESPONSIBILITIES.

Patient Signature _____ **Date**_____

OUT OF POCKET ACCOUNTS:

Payment is due at time of service. By choosing to pay out of pocket, ***your insurance company will not be billed****. Please acknowledge the acceptance of this policy by signing and dating on the line below.*

_____ *DATE* _____

(If your insurance isn't involved, sign here)