

NAME:

Patient Medical History

Please circle yes or no:

- | | | | | | |
|--|-----|----|---|-----|----------|
| Diabetes | yes | no | Sensitivity to Heat | yes | no |
| High Blood Pressure. | yes | no | Sensitivity to Ice | yes | no |
| Heart Disease. | yes | no | Allergies | yes | no |
| Heart Attack (Myocardial Infarction) . | yes | no | Headaches | yes | no |
| Previous Surgery. | yes | no | Seizures | yes | no |
| Pacemaker. | yes | no | Hernia | yes | no |
| Cancer. | yes | no | Kidney Problems | yes | no |
| Metal Implants. | yes | no | Stents, Artery Bypass | yes | no |
| Valvular Disease. | yes | no | Coronary Artery bypass Graft: | yes | no |
| Arrhythmia | yes | no | Osteoporosis | yes | no |
| Angioplasty | 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 | Stroke/TIA | yes | no |
| Taking Blood Pressure Meds | yes | no | Atherosclerotic Disease | yes | no |
| Acquired Respiratory Distress Syndrome (ARDS) | yes | no | | | |

General Medical Conditions:

- | | | | | | |
|---|-----|----|-------------------------------------|-----|----|
| Arthritis (Rheumatoid/Osteoarthritis) | yes | no | Anxiety or Panic Disorder | yes | no |
| Bladder, Prostate or Urination Problems | yes | no | Depression | yes | no |
| Hearing Impairment | yes | no | Incontinence | yes | no |
| (very hard of hearing with hearing aids) | | | Sleepy Dysfunction | yes | no |
| Gastrointestinal Disease | yes | no | Smoker | yes | no |
| (Ulcers, Hernia, Reflux, Bowel, | | | (# of packs/Day)_____ | | |
| Liver, Gall Bladder) | | | Alcohol/Drug Addiction | yes | no |
| Visual Impairment | yes | no | Prosthesis/Implants | yes | no |
| (such as Cataracts, Glaucoma, | | | Neurological Disease. | yes | no |
| Macular Degeneration) | | | (such as MS or Parkinson's) | | |
| Back Pain | yes | no | | | |
| (Neck Pain, Low Back Pain, | | | | | |
| Degenerative Disc Disease, | | | | | |
| Spinal Stenosis) | | | | | |

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)