# NEW PATIENT FORM

PLEASE PRINT CLEARLY

**Date**:_______________________________

**Name** (First)________________________________ (Last)____________________________________ (M.I.)___________

Home Address______________________________________________________________________________________

City____________________________________________________ State________________ Zip ________________________

Primary Phone (____) ________________ Secondary Phone (____) ______________ Other Phone (____) ________________

Social Security #________________________________ Birth Date__________________ Age_______ Sex ☐ M ☐ F

Drivers Lic #_________________________ State _________ Email Address___________________________________________

*(Your email will be added to PSM's database - we will not sell or give away your info)*

**Status** ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner ☐ Separated ☐ Widowed

**Emergency Contact**___________________________________________ Telephone (_____) _____________________________

**Referring Physician**__________________________________________ Telephone (_____) _____________________________

**Who may we thank for your referral other than your doctor?** ___________________________________________________

**Employment Status** ☐ Full-time ☐ Part-time ☐ Not working ☐ Student **Employer**___________________________

Address ______________________________________________________Telephone (_____) _____________________________

**Injury Type** ☐ Work ☐ Auto ☐ Home ☐ Other___________________________ Injury Date_______________________

**Attorney Involved** ☐ No ☐ Yes If Yes, then Attorney Name____________________________________________________

Address _____________________________________________________ Telephone (_____) _____________________________

## Insurance Patients Only

**Primary Insurance** _____________________________________________________________________________________

Insured Name _____________________________ Social Sec# _______________________ D.O.B. ____________________

**Secondary Insurance** ___________________________________________________________________________________

Insured Name _____________________________ Social Sec# _______________________ D.O.B. ____________________

*Please note that you are financially responsible for any charges not covered by your insurance plan*

**How would you prefer to receive statements from our medical billing company?** *(Please check one)*

☐ **E mail** ☐ **Mail** ☐ **Fax** (_____) ______________________________

**Patient Signature** ______________________________________________________ **Date** _____________________

PRESIDIO
Sport & Medicine

# MEDICAL HISTORY

Patient Name________________________________________ Age__________

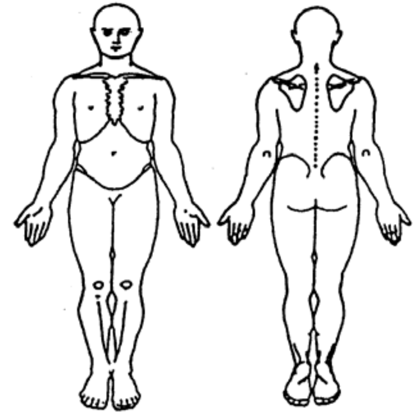
Type of Injury / Condition ______________________________ Onset / Injury Date______________

Type of Surgery & Date ______________________________

Next Doctor's Appointment? ______________________________

Describe previous treatment for this condition______________________________

______________________________



**Please mark the area(s) of concern**

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No

**Have you had any imaging performed:**

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

**Have you recently noted any of the following:**

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs when Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision Or Hearing
- ☐ Insomnia

**Do you have now or have you ever had any of the following:**

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________________

Explain & give approximate dates for any items indicated above ______________________________

Are you currently taking medications? Yes / No Name or Type of Medication ______________________________

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ______________________________

Rate your pain (1=minimal 10=severe): At it's <u>worst</u>: 1 2 3 4 5 6 7 8 9 10 / At it's <u>best</u>: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?______________________________

______________________________

What are your current physical or fitness goals______________________________

In 6 months______________________________

In 12 months______________________________

Is there anything else you would like to include or ask your physical therapist? ______________________________

**Patient Signature** ______________________________ **Date** ______________

# OFFICE POLICY

**CONSENT FOR TREATMENT OF A MINOR:** As parent and/or legal guardian, I authorize Presidio Sport & Medicine to treat the minor patient named in the attached forms while I am not present.

**Parent/Guardian Signature** ________________________________________ **Date**________________

**CONSENT FOR CARE & TREATMENT:** I understand that Presidio Sport & Medicine is a teaching facility and that part of my treatment may be administered by a physical therapy intern. I the undersigned do hereby agree and give my consent for Presidio Sport & Medicine to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. ____ ***(initial)***

**CANCELLATION & NO-SHOW POLICY:** Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. For the best customer service, we ask that you make schedule changes during our normal business hours. Please keep in mind that if the requested notice is provided, then we can better reallocate the time to someone else in need of treatment. Appointments cancelled with less than 24-hours notice will be assessed a fee as follows: $40 for physical therapy office visits, $80 for initial evaluations, and the full price for massages. This fee is not covered by insurance and is your responsibility to pay at the time of your next visit. ____ ***(initial)***

---

## INSURANCE PATIENTS ONLY

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize **Presidio Sport & Medicine** to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Presidio Sport & Medicine. ____ ***(initial)***

**FINANCIAL POLICY:** If you have provided your insurance information to our office, then we bill your insurance company as a courtesy and will assist you to the best of our abilities with getting your claim paid. However, you are financially responsible for any charges not covered by your insurance plan. In an effort to keep our fees low and your costs manageable, we will collect $____________________________________________ at the time of service. Please note that what we collect in the office is only a ***portion*** of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement from our billing company. You are ultimately financially responsible for medical services rendered to you. We have reviewed these benefits with you and you agree to pay your portion of your bill. ____ ***(initial)***

---

## SELF PAY PATIENTS ONLY

**FINANCIAL POLICY:** For patients without insurance, we offer self-pay rates. Payment for self-pay services is due at the time of service. We also offer discounted packages which must be purchased in advance. If you exceed your prepaid package, you will receive a bill from us and we expect prompt payment. If you do not use all of your prepaid package, you may apply the unused portion to other services at Presidio Sport & Medicine. Refunds of unused portions may be granted in unusual circumstances; however the used portion will be converted from the discounted package rate to the self-pay rate before a refund is issued. ____ ***(initial)***

---

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

________________________________________ ____________________

**Patient Signature** (Parent/Guardian, if patient is a minor) **Date**

# HIPAA NOTIFICATION

## Notice of Privacy Practices for Protected Health Information
## Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Presidio Sport & Medicine is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either on paper or electronically.

**If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below. If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it.**

### Acknowledgement

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ________________________________________

Signature: __________________________________________

Date Signed: ________________________________________

**OR**

### Waiver

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice. I am aware that this Notice is available to me online at Presidio Sport & Medicine's website, www.presidiosport.com, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ________________________________________

Signature: __________________________________________

Date Signed: ________________________________________