ProCare Physical Therapy
Professional therapy delivered with care

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		
Email Address:	Spouse:		

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto : ☐ Labor & Industries:

Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to ProCare Physical Therapy I understand that I am financially responsible for any balance. I also authorize ProCare Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Cancer (presently or history of)	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

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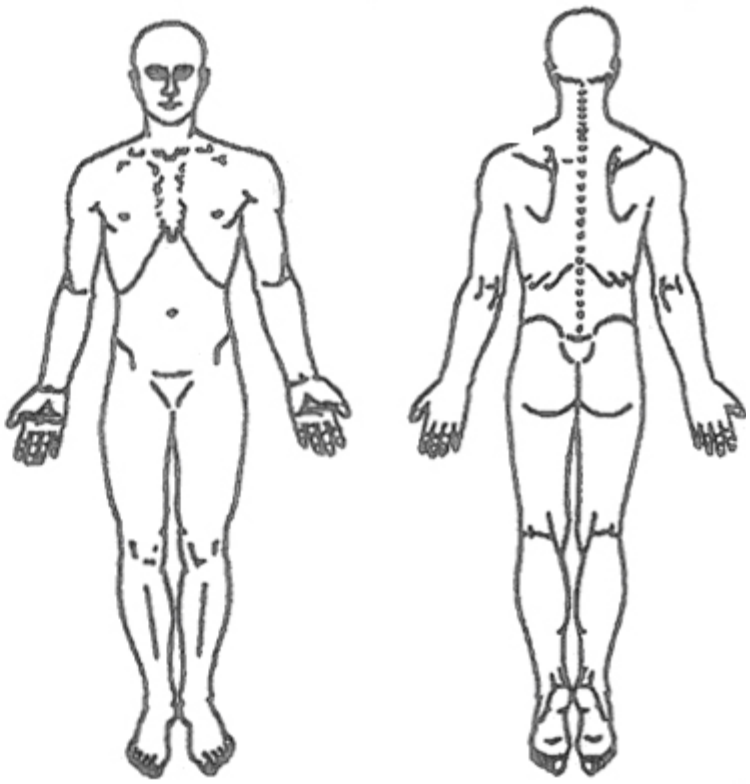
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / /	x x x x
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____
Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____

ProCare Physical Therapy

AUTHORIZATION TO PAY PROCARE PHYSICAL THERAPY

Assignment of Benefits and Agreement of Payment

I hereby authorize my insurance benefits to be paid directly to ProCare Physical Therapy and I understand that I am financially responsible for any non-covered charges or services incurred regardless of insurance or third party liability. I also authorize ProCare Physical Therapy to release any medical information necessary to process this claim to my insurance company or to any other concerned third party. I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a third party agency and/or attorney for collections or legal action. I authorize contact by the use of my home or cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.

Additional Terms:

Payments: Unless other arrangements have been approved by management, payment for services is due at time services are rendered. Payment can be made by cash, check, or debit/credit card.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company, and/or a higher patient financial responsibility.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. If we are NOT a party to this contract, we will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is only an estimate and it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by your insurance.

NO Insurance/Cash Pay: If you have no insurance you can pay cash. Payment is expected at time services are rendered and can be made in the form of cash, check, or debit/credit card.

Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Missed Appointments: We reserve the right to charge a $25 fee for a third consecutive missed appointment. The fee must be paid before a new appointment is scheduled. We also may ask you to switch to same day only scheduling.

Patient's Name: _____

Responsible Party: _____
(if not the patient)

Signature: _____

Date: _____

1752 Orange Tree Lane • Redlands, California 92374
(909) 307-2244 • Fax (909) 307-2254 • www.procarept.net

ProCare Physical Therapy

Photo Release Form for Adults

ProCare Physical Therapy has my permission to use my photograph for promotional purposes. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Signature: _____Date_____

Name: _____

Photo Release Form for Minors (if under 18)

ProCare Physical Therapy has my permission to use my or my child's photograph for promotional purposes. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian's signature: _____Date_____

Parent/Guardian's Name: _____

Child's Name: _____

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ProCare Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Patient ID #:** _____

I hereby acknowledge that I have received a copy of ProCare Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____