North County Sports Medicine and Physical Therapy

Put Your Health and Wellness In Good Hands

4055 Oceanside Blvd Suite F, Oceanside CA 92056
P:760.842.7519
F:760.657.2994

NEW PATIENT INFORMATION

Name:_____DOB: _____ Age: _____ Gender: ____

SSN: _____

Phone: _____

Address:_____

City: _____State:_____Zip:_____

Email:_____

Occupation: _____

Emergency Contact:_____Phone_____

Referring physician: _____

Body part to be treated: _____

How did you hear about us?

_____

Special notes relating to new patient or registration

_____

_____

_____

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HEALTH HISTORY

Name:_____ Date: _____

Do you have a history of high blood pressure? Yes_____ No_____

Do you have a history of heart problems? Yes_____ No_____

Do you have a pacemaker implant? Yes_____ No_____

Do you have any metal implants (pins, plates, screws, IUD)? Yes_____ No_____

Do you have any sensory impairment? Yes_____ No_____

Are you pregnant? Yes_____ No_____

Do you have any history of diabetes? Yes_____ No_____

Do you have any history of cancer? Yes_____ No_____

Do you have any history of circulatory problems? Yes_____ No_____

Do you have any history of seizures? Yes_____ No_____

Do you have any history of broken bones? Yes_____ No_____

Do you have any history of any type of hepatitis? Yes_____ No_____

Have you had any unintended weight loss recently? Yes_____ No_____

Are you currently taking any medications? Yes_____ No_____

Please list any medications you are currently taking _____

_____

Please list any surgeries you have had in the past _____

Have you ever had physical therapy before? Yes_____ No_____

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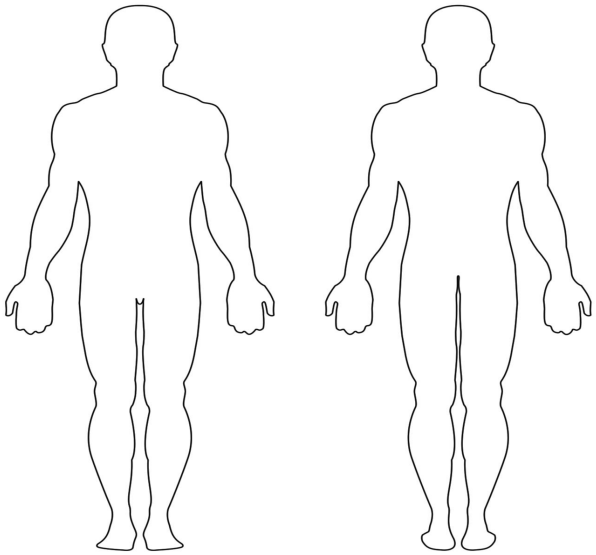
1. What body problem(s) are you hoping to correct with physical therapy?

2. What have you heard about physical therapy?

3. What is the goal you hope to achieve with therapy and why?

4. Do you have any concerns about physical therapy?

5. Where is your pain? Please mark on the drawings below the area(s) where you feel pain.



6. Pain Scale. Please mark your CURRENT pain on the line below.

(No pain)____0 ____1 _____ 2 ____ 3 ____ 4 ____5 ____6 ____7 ____8 ____9 ____10 (Max pain)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & PATIENT INFORMATION

I have read and fully understand North County Sports Medicine and Physical Therapy Notice of Patient Information Practices.

I authorize North County Sports Medicine and Physical Therapy to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to therapy treatment or examination rendered to me.

I understand that this medical information may be used or disclosed for the following purposes: diagnostic, carrying out treatment, evaluating the quality of services provided, when deemed necessary to ensure the best medical care on my behalf, obtaining payment, insurance, legal, and any administrative operations related to treatment or payment.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA); however, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. Please indicate below any information that you do not wish disclosed or any entities that you do not permit to receive information:

_____

_____

_____

I also understand that North County Sports Medicine and Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in North County Sports Medicine and Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent at any time. If I decide to restrict or revoke this authorization for my health information, I must notify the practice in writing, signed by me or on my behalf. I hereby release North County Sports Medicine and Physical Therapy and its employees from any liability from the release of this information.

Patient Signature: _____Date: _____

Print Patient Name:_____

Responsible Party (if patient is a minor): _____

Signature

4055 Oceanside Blvd Suite F ▪ Oceanside, CA 92056 Phone:760.842.7519 ▪ Email: info@northcountysportsmed.com

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TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at this clinic because it can make a difference between whether you succeed in your treatment or not. Either your therapist or your referring doctor will/has prescribed a set frequency of treatment visits and showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow our therapist's instructions and we will be able to help you achieve your goals in treatment.

If it is necessary for you to reschedule an appointment, please call at least 24 hours in advance. When you call, please be prepared to reschedule that appointment to ensure you get in the full-prescribed number of treatments that week.

Please be on time for all of your scheduled appointments. If you arrive 10 minutes after your treatment time, you may not be seen for your appointment. This appointment may be counted as a cancellation without prior notice.

There is a $35 service fee for no-shows or cancellations without prior notice. This charge will not be covered by insurance and this will need to be paid prior to further treatments. If you no-show without proper notice a second time, you may be billed a $35 service fee and discharged back to your referring physician without an explanation.

For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Referring Physician and this could jeopardize your claim.

Please understand that your pain will probably increase and decrease as your course of treatment progresses. Neither of these conditions is legitimate as a reason skip an appointment: a) if you're in pain, come in and we can help to alleviate it, b) if your pain has decreased, now is the time that we can do more correction of the underlying causes of your problem and educate you to prevent further injury.

When you don't show up as scheduled, three people are hurt: 1) You, because you don't get the treatment you need as prescribed by the doctor, 2) the therapist, who now has a space in their schedule since the time was reserved for you personally, and 3) another patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We are looking forward to working with you to achieve your best possible outcome!

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party (if Patient is a minor): _____

Signature

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical therapy (PT) involves the use of many different types of physical evaluation and treatment. At North County Sports Medicine and Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. I acknowledge that my treatment program has been explained by North County Sports Medicine and Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____ _____ _____

Patient Name Signature Date

Responsible Party (if Patient is a minor): _____

Signature

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