

Sequoia Physical Therapy

Private Ins. _____ Worker's Comp _____ Medicare _____ Contract _____

Patient Information- PLEASE PRINT LEDGIBLY

Name _____ (M / F) Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____ Cell Phone _____
Date of Birth _____ Social Security # _____
Emergency Contact _____ Emergency Phone _____

Insurance Information

Insurance Co Name _____ WC Claim Number _____
Phone Number _____ Health Plan ID _____
Insurance Address _____ Medical Group _____
City, State, Zip _____

Referring MD Name _____ Phone # _____
Attorney Name _____ Phone# _____
Address _____
City, State, Zip _____

Medical Information –Please check if you have the following:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Herpes/Shingles
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Pacemaker/Arrythmias
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Joint Replacement/Metal Implants
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Gastrointestinal Problems

Please check below if you suffer from any of the following symptoms:

<input type="checkbox"/> Bowel or Bladder changes	<input type="checkbox"/> Fever	<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Night pain	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Menstrual Changes	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Muscle fatigue or weakness	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Unexplained weight loss(>10 lbs)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Fainting/Unconsciousness

If you answered Yes to any of the above, are you currently or have you previously been under a physicians care for that disorder? Yes _____ No _____

Please list any other information regarding past medical history, previous injuries, previous surgeries, etc. _____

OFFICE USE ONLY:

Diagnosis: _____ BPK _____ Orange _____
WC Only D.O.I. _____

Eval Date _____ RX Date: _____

Please list any medications that you are currently taking: _____

Are you now or have you taken any steroid medication? (e.g. Prednisone) Yes ___ No ___

Are you currently taking any anticoagulant medications? (e.g. Coumadin) Yes ___ No ___

Have you had a recent cortisone shot? Yes ___ No __. If yes) when? _____

Please list any diagnostic tests that have been done for this condition (Hays, MRI, EMG, bone scan, etc)

TEST	DATE	RESULT
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT RIGHTS

We are required by law to inform you of your rights as a patient, which includes how your medical information may be used and disclosed and how you can get access to this information. Please review the literature that is available at our reception counter. If you have any questions, you can speak to our Privacy Contact, Ron Cram.

Pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, Sequoia Physical Therapy does not discriminate on the basis of race, color, national origin, handicap or age.

PATIENT AGREEMENT AND CONSENTS

I understand Sequoia Physical Therapy will bill my insurance company as a courtesy and hereby authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible to verify insurance benefits. I am responsible for any indebtedness incurred for treatment/cancellation for myself or my dependents regardless of insurance coverage. I am responsible for resolving any insurance coverage or payment problems. Payment from my insurance company is expected by this office within 60 days of the billing date. If payment is not received within this period, I agree to begin making payments. Returned checks incur a \$15.00 charge.

I understand the importance of coming to appointments on time. I understand twenty four (24) hours notice is required to cancel an appointment or a charge of \$50 may be applied to my account unless an emergency has arisen. Multiple cancellations/no shows may result in discontinued care due to non-compliance. I understand the policies and hereby consent to treatment. ___ Initial

Should any legal action be required by Sequoia Physical Therapy, Inc. to enforce the terms of this agreement and receive monies owed, I hereby agree that the prevailing party shall be entitled to actual costs and reasonable attorney's fees. Please acknowledge by signature that you understand this agreement, and are informed of your rights as a patient.

Printed Name _____

Signature _____ Date _____