

Confidential Medical History/Evaluation

Physical therapy for the body, mind, and spirit

SPIRIT WINDS
therapy

Name: _____ Date: ____/____/____

Who recommended you to Spirit Winds Physical Therapy? MD: _____ Friend/Family: _____

Chief Complaint: _____ Date of Injury/Onset: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible. Indicate the severity of pain on a scale of 0= none 10= severe (excruciating pain).



Parasthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, ect.)



List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other: _____

Do you have any of the following?

Pain when performing the following activities?

	YES	NO		Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema	_____	_____	Bending	_____	_____	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Care for Infirm Family	_____	_____	_____	_____
Coronary Hear Disease	_____	_____	Carrying Groceries	_____	_____	_____	_____
Do you have a Pacemaker	_____	_____	Changing Pos (Sit to Stand)	_____	_____	_____	_____
High Blood Pressure	_____	_____	Changing Pos in Bed	_____	_____	_____	_____
Heart Attack/ Surgery	_____	_____	Climbing Stairs	_____	_____	_____	_____
Stroke/TIA	_____	_____	Driving	_____	_____	_____	_____
Blood Clot/Emboli	_____	_____	Extended Computer Use	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	Feeding (Self)	_____	_____	_____	_____
Thyroid Trouble/Goiter	_____	_____	Household Chores	_____	_____	_____	_____
Anemia	_____	_____	Kneeling	_____	_____	_____	_____
Infectious Disease	_____	_____	Lift Children	_____	_____	_____	_____
Diabetes	_____	_____	Lifting	_____	_____	_____	_____
Cancer or Chemo/Radiation	_____	_____	Pet Care	_____	_____	_____	_____
Arthritis/Swollen Joints	_____	_____	Reading (Concentration)	_____	_____	_____	_____
Osteoporosis	_____	_____	Self Care-Bathing	_____	_____	_____	_____
Varicose Veins	_____	_____	Self Care-Dressing	_____	_____	_____	_____
Gout	_____	_____	Self Care-Shaving	_____	_____	_____	_____
Sleeping Difficulties	_____	_____	Sexual Activity	_____	_____	_____	_____
Emotional/Psychological Problems	_____	_____	Sleep	_____	_____	_____	_____
Bowel or Bladder Problems	_____	_____	Sitting (Prolonged)	_____	_____	_____	_____
Severe/Frequent Headaches	_____	_____	Walking (Prolonged)	_____	_____	_____	_____
Vision/Hearing Difficulties	_____	_____	Yard Work	_____	_____	_____	_____
Dizziness or Faintness	_____	_____	Sports	_____	_____	_____	_____
Are you Pregnant?	_____	_____	Recreational Activities	_____			
Smoking	Daily _____	Weekly _____	Exercise	Daily _____	Weekly _____		
Alcohol Consumption	Daily _____	Weekly _____					

Other Medical Conditions: _____



*Spirit Winds Physical Therapy is committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.*

INFORMED CONSENT

Standard of Practice and Code of Ethics

I have the following rights & privileges:

- The right to disclosure regarding costs and benefits;
- The right to make the decision regarding what happens to my body;
- The privilege to question risk associated with any proposed treatment;
- The privilege to request expected benefits of any proposed treatment.

I certify that all information I have provided is true and correct to the best of my knowledge.

I consent to the techniques practiced by Spirit Winds Physical Therapy.

Patient (or Guardian) Signature _____

Notice of Privacy Practices - Patient Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practice form posted in our office which details the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Insurance Co-Payments/Coinsurance & Patient Financial Responsibility

Financial Policy Acknowledgement:

It is the Patient's responsibility:

- To know his/her insurance policy. Patients should be aware of the benefit coverage, including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements and cost share information such as deductibles, coinsurance and co-payments. **If you are not familiar with your plan coverage, we recommend you contact your carrier directly.**
- To obtain a referral from his/her Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier **prior to receiving services. Any non-covered services are the financial responsibility of the patient.**
- To pay his/her co-payment at the time of service.
- To pay any deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by his/her insurance carrier.
- To facilitate in claims payment by contacting his/her insurance carrier when claims have not been paid.

It is Spirit Winds Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A sixty (60) day period will be extended for pending insurance payment, after which the patient pay be held responsible for the balance.

Insurance Co-payments & Coinsurance:

Insurance co-payment and coinsurance involves an official, legal signed agreement that we (Spirit Winds Physical Therapy) have with you insurance company. **The act of dismissing an insurance co-payment or coinsurance is considered Medical Insurance Fraud in California.** In order to maintain standards and ethics in our business, we **MUST** collect each insurance co-payment or coinsurance for a physical therapy visit. Those patients who refuse to pay insurance co-payment or coinsurance will

be discharged from physical therapy. Upon discharge, the referring and primary care physician will be immediately notified verbally and through documentation.

Regardless of my insurance claim status or absence of insurance coverage, **I am ultimately responsible for the balance on my account for any services rendered.**

I understand Spirit Winds Physical Therapy's Financial, Co-Payment and Coinsurance policies:

Patient Signature

Date

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to:

Spirit Winds Physical Therapy
1422 Monterey Street, C-102
San Luis Obispo, CA 93401

Any medical or professional expenses paid by my current insurance policy will go towards fees for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees and above the insurance payment or as required by my insurance policy.**

PLEASE NOTE FOR MEDICARE SUBSCRIBERS:

There is a financial limitation of \$1,840 for Physical and Speech Therapy for the 2009 calendar year. You will be fiscally responsible for any fees above what is covered by Medicare and/or your secondary insurance. **Patient Initials** _____

A photocopy of this Assignment shall be considered effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney for the purpose of securing payment under this policy of insurance.

Patient Name (Printed)

Patient Signature

Parent or Guardian (Printed)

Parent or Guardian Signature

MISSED APPOINTMENTS POLICY

We strive to provide our patients with excellent service and quality care. Our commitment to your well being and health is something that we at *Spirit Winds Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals with you. In order to reach those goals, you must do your part. Your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all of your appointments; however, should you need to cancel, please note that we require twenty-four (24) hours notice.

If you need to cancel, please call our office and reschedule. **If you do not cancel within twenty-four (24) hours of your visit, or if you do not attend an appointment without prior notice, you will be charged \$50 for the missed appointment.**

If you miss three (3) consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Spirit Winds Physical Therapy*. We look forward to working with you to help you reach your goals.

I have read and understand this policy.

Patient/Guardian

Date