MISSION
PHYSICAL THERAPY GROUP
NORTH COUNTY PT | CREEKSIDE PT

NORTH COUNTY PHYSICAL THERAPY, INC. DBA MISSION PHYSICAL THERAPY GROUP

Last Name _____ First Name _____ MI _____

Mailing Address _____ City _____ State_____ Zip_____

Date of Birth _____ Age_____ SSN: _____-_____-_____ Gender: M or F

Home Phone _____ Cell Phone _____

Email: _____

Patient Employer _____ Phone: _____

Referring Physician _____ Date of Injury _____ Date of Surgery_____

Primary Physician _____

EMERGENCY CONTACT

Last Name _____ First Name _____

Relationship to Patient _____ Phone _____

IF PATIENT IS A MINOR PLEASE PROVIDE US WITH FOLLOWING INFORMATION

Parent/ Guardian Name _____ DOB: _____

SSN: _____-_____-_____

INSURANCE

Primary Insurance _____ (please present card @ time of service)

Secondary Insurance _____

Was This a Motor Vehicle Accident _____ IF YES PLEASE COMPLETE THE FOLLOWING:

Name of Vehicle Insurance _____ Phone: _____

Name of person insured _____ Accident claim# _____

Adjustor Name: _____

I authorize North County Physical Therapy, Inc. dba Mission Physical Therapy Group to provide treatment as medically necessary.

I assign payment of medical benefits to North County Physical Therapy, Inc. dba Mission Physical Therapy Group. I understand that I am fully responsible for any balance due. North County Physical Therapy, Inc. dba Mission Physical Therapy Group will bill my insurance company as a courtesy. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE PROVIDER TO VERIFY OUTPATIENT PHYSICAL THERAPY BENEFITS.

I authorize release of medical records, information, requested by my insurance plan for reimbursement.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

PATIENT HISTORY

NAME: _____ DATE OF NEXT MD APPOINTMENT: _____

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:
Onset Date: _____ Description: _____

_____

_____

Please list any special concerns, questions or expectations: _____

_____

Have you fallen in the past year? _____ If so, how many times? _____ If so, did you sustain an injury? _____

Have you had any physical therapy during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

_____

List **ALL** medications you are currently taking: _____

_____

_____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stents, etc.?
Describe _____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: _____

_____

_____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

_____

_____

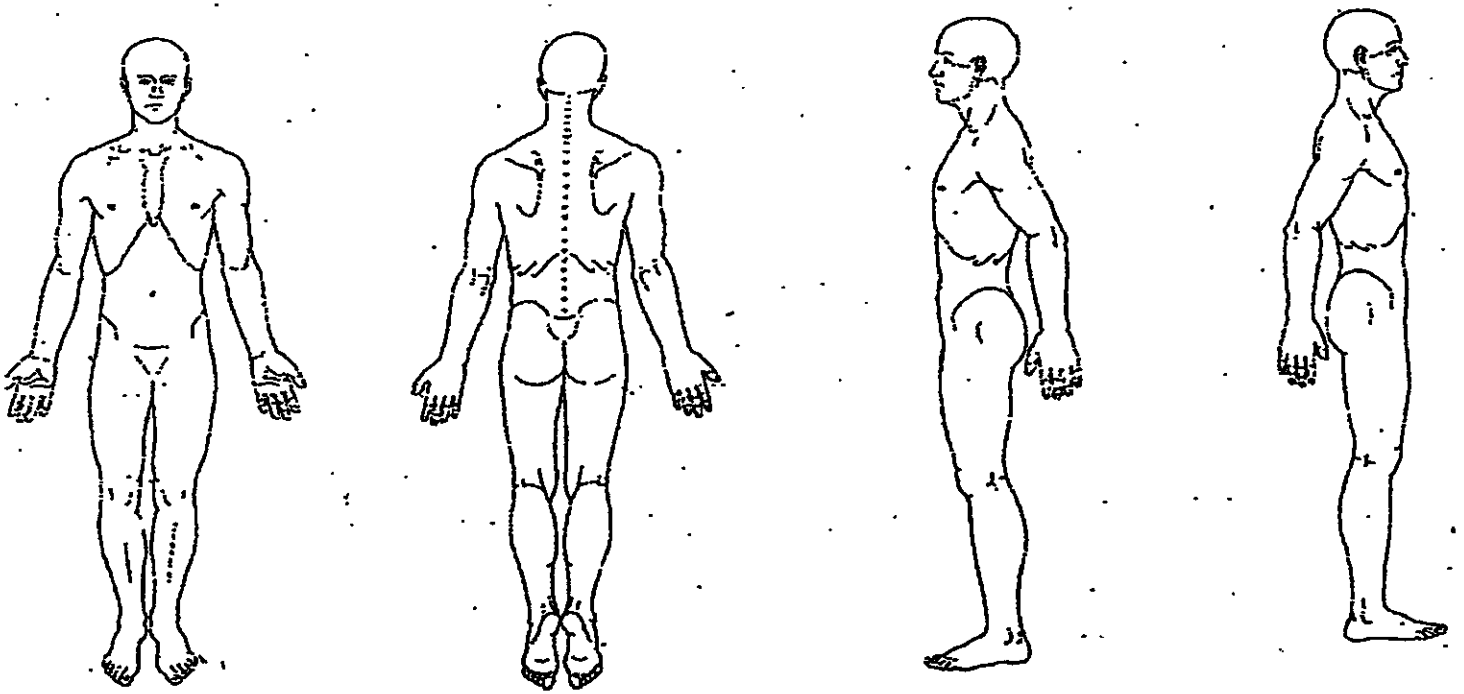
Height _____ Weight _____

SIGNATURE: _____ DATE: _____

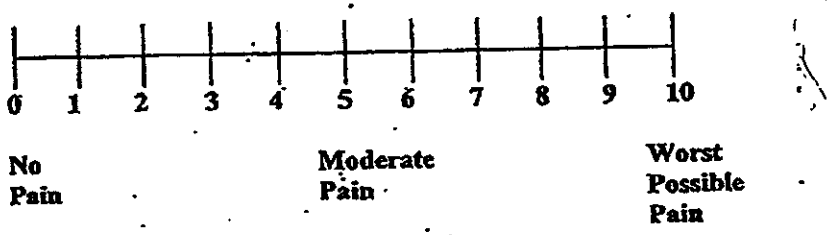
Name:_____

Pain Diagram

Date:_____



Please circle where you are having pain.



Please mark on the line where you feel the correct intensity of your pain lies.

North County Physical Therapy, Inc. dba Mission Physical Therapy Group)

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand North County Physical Therapy, Inc. dba Mission Physical Therapy Group Notice of Information Practices. I understand that North County Physical Therapy, Inc. dba Mission Physical Therapy Group may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. 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. I also understand that North County Physical Therapy, Inc. dba Mission Physical Therapy Group will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in North County Physical Therapy, Inc. dba Mission Physical Therapy Group Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Signature Date

Initial below for agreement: (optional)

_____ I also authorize North County Physical Therapy, Inc. dba Mission Physical Therapy Group to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Appointment Reminder Consent

You have the option to receive appointment reminders via email or text. To give North County Physical Therapy, Inc. dba Mission Physical Therapy Group permission to provide this service, please provide either your email or cell phone information and sign below.

Please select one option below:

_____ North County Physical Therapy, Inc. dba Mission Physical Therapy Group may send email messages to confirm my upcoming appointments to the following

email: _____

_____ North County Physical Therapy, Inc. dba Mission Physical Therapy Group may send cell phone text messages to confirm my upcoming appointments to the

following **cell phone #:** _____

Please indicate your cell phone carrier: _____

***** I recognize that normal text messaging rates may apply*****

Patient / Guardian Signature: _____ Date_____

North County Physical Therapy, Inc. dba Mission Physical Therapy Group
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

North County Physical Therapy, Inc. dba Mission Physical Therapy Group's Legal Duty

North County Physical Therapy, Inc. dba Mission Physical Therapy Group is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

North County Physical Therapy, Inc. dba Mission Physical Therapy Group uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, North County Physical Therapy, Inc. dba Mission Physical Therapy Group may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

North County Physical Therapy, Inc. dba Mission Physical Therapy Group may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, North County Physical Therapy, Inc. dba Mission Physical Therapy Group policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

North County Physical Therapy, Inc. dba Mission Physical Therapy Group may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. North County Physical Therapy, Inc. dba Mission Physical Therapy Group will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that North County Physical Therapy, Inc. dba Mission Physical Therapy Group may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on North County Physical Therapy, Inc. dba Mission Physical Therapy Group health information practices or if you have a complaint, please contact the following person:

North County Physical Therapy, Inc. dba Mission Physical Therapy Group
Mary Ann Burke, MSPT
1191 Creston Rd, #115
Paso Robles, CA 93402
Telephone: 805.239.3696 **Fax: 805.239.3697**