

Personally Fit, Inc.

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit ____ / ____ / ____
Referred By _____
Latest Referral Information _____ Motor Vehicle Accident _____
Latest Plan of Care _____ That occurred in: _____
Notes: _____

Primary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	ColInsurance _____
		Date of Birth _____

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	ColInsurance _____
		Date of Birth _____

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____	CoPay _____	ColInsurance _____
		Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Fincancial Responsibility form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
I authorize Perosnally Fit, Inc to provide email notifications with the above email.
(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____



Personally Fit

FITNESS & PHYSICAL THERAPY

Direct Physical Therapy Treatment Services Disclosure Statement

You are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient Signature

Printed Name

Date



Personally Fit
FITNESS & PHYSICAL THERAPY

16680 West Bernardo Drive San Diego, CA 92127 Phone: 858-485-6706 Fax: 858-485-7052

Patient Statement of Financial Responsibility

Thank you for choosing Personally Fit for your physical therapy needs. Our staff is committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services.

Please be sure that you have read and understand all the information provided in this statement before signing the release. As our patient, your signature is both binding and acknowledges your understanding and compliances with our policies.

Cancellations and Missed Appointments

In order to be respectful of the medical needs of others, please call our office at least one business day in advance if you are unable to attend or must reschedule an appointment. If you do not comply with our cancellation policy, there is a \$25 cancellation fee. As a courtesy to you, we allow two cancellations without charge. Patient's arriving late may have their treatment time adjusted accordingly.

For your convenience, our phone number is (858)485-6706. If it is after hours, please leave a message.

Payment for Office Visits

For the convenience of our patients we accept cash, Visa, MasterCard, Discover, and checks.

Returned checks are subject to a \$25 return fee.

Self-Pay Patients

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance assume full financial responsibility for the visit and any services rendered during the time of service.

Medicare Patients

We accept the Medicare assignment of covered charges. If applicable, we bill supplemental insurance the remaining 20% co-insurance that Medicare does not cover or any uncovered charges and any remaining balance will be patient responsibility. Benefits are only available for medically appropriate and necessary treatment that is covered according to the terms of the benefits plan and subject to the patient's eligibility on the date of service. Benefits will be denied if the member is not eligible on the date of service.

Direct Access Therapy Treatment Services Disclosure Statement

You may be receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California without a referral from a physician.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person examination and evaluation was conducted by the physician and surgeon or podiatrist.

Workers Compensation Patients

We must have prior authorization in office from the workers compensation agent or carrier in order to treat. Should the employer or carrier deny validated worker's compensation service, such charges will be the financial responsibility of the patient.

Insurance Patients

Summary of Benefits

As a courtesy, our office contacts your insurance to verify your coverage. However, Personally Fit Inc. does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plan. This is not a guarantee of payment and is subject to change according to the policy agreed upon between you and your insurance.

Deductible* (if applicable): _____

Co-insurance _____ **Copay*** _____

*Copayments required by the individual insurance plans are to be collected at the time of service. Deductibles may be collected in increments until amount is satisfied. See front desk for additional information.

Visit Limit: _____ **per calendar/service year**

Other Information: _____

Prior Authorization Required:** **Yes or No**

**Please Note: It is the patient's responsibility to ensure the services rendered are covered by insurance prior to their appointment. As a provider, we will do our best to work with you and your insurance in order to get approval for services rendered at Personally Fit Inc.

This is a description of benefits, as given to us by your insurance company. This information is provided to you as a courtesy only. It is the patient's responsibility to check with your insurance to verify benefits/coverage. I fully understand that any unpaid portion of services rendered is my responsibility.

Release of Information and Consent to Treatment

Initials

I attest to the fact that all information herein is true and correct. I am aware of my diagnosis and wish to receive treatment. No guarantees have been made to me about the outcome of this care. I give permission to Personally Fit Inc. to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided. I authorize Personally Fit Inc. to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment

Notice of Privacy Policy (HIPAA Acknowledgement/Consent)

Initials

I hereby acknowledge that I am aware of The Notice of Privacy Practices for Personally Fit Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. See front desk to review our privacy practices in detail.

Y N
NONE

Email Authorization

Your email may be used to provide courtesy appointment reminders the day before your scheduled appointment. We may also email you our company newsletter about current events at Personally Fit Inc. Please select if you would prefer e-mail reminders for your appointments. Please select Y for Yes if you would like to receive email reminders for your appointments or N for No if you would like to opt-out of email reminders and prefer a phone call. Select "None" if you do not wish to receive a reminder for your appointment at all.

RELEASE

I hereby acknowledge that I have read, understand, and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections, I will be charged the collections service fee in addition to all outstanding balances.

Signature of Patient/ Guarantor

Printed Name

Date: _____



Personally Fit

FITNESS & PHYSICAL THERAPY

16680 West Bernardo Drive, San Diego, CA 92127 858-485-6706 Fax 858-485-7052

Patient's Name _____

Is this an injury or accident case? Yes No If yes, is there an attorney involved? Yes No

Are you currently taking any prescription or non-prescription medications Yes No
(Includes vitamins, supplements, and over the counter medications)

If Yes, please list the medications and the dosages:	Medications	Dosage
Height _____	_____	_____
Weight _____	_____	_____

- | | | | |
|----------------------------------|--|--------------------------------|--|
| Asthma, Bronchitis, or Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe or Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary Heart Disease or Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision or Hearing Difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of Breath/Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness or Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack or Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel or Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke/TIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestive Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clot/Emboli | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss/Energy Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pins or Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infectious Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer or Chemo/Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulder Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbow/Hand Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleeping Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankle/Foot Injury/Surge | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emotional/Psychological Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do You have a Pacemaker? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any other information that you feel would assist us in your care: _____

Have you experienced any falls over the past year: Yes No

If yes, approximately how many? _____ Any injury? Yes No

Patient/Guardian Signature _____ Date _____

Physical Therapist Signature _____ Date _____

Date _____
 Name _____

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
Column Totals:						

Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: ____ / 80

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. *Physical Therapy*. 79:371-383.