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 _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

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

Personally Fit
FITNESS & PHYSICAL THERAPY

Shoulder Pain and Disability Index (SPADI)

Please answer the following questions by marking a number from 0-10 on the scale below. If you feel a question does not pertain to you please put NA (not applicable) in the space. We will ask you to repeat this index in order to help our facility keep track of our treatment outcomes. Thank You.

Name:_____ **Date:**_____

Pain scale

How severe is your pain?

Circle the number that best describes your pain where: 0 = no pain and 10 = the worst pain imaginable.

At its worst?	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10

Disability scale

How much difficulty do you have?

Circle the number that best describes your experience where: 0 = no difficulty and 10 = so difficult it requires help.

Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
Washing your back?	0	1	2	3	4	5	6	7	8	9	10
Putting on an undershirt or jumper?	0	1	2	3	4	5	6	7	8	9	10
Putting on a shirt that buttons down the front?	0	1	2	3	4	5	6	7	8	9	10
Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10
Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Carrying a heavy object of 10 pounds (4.5 kilograms)	0	1	2	3	4	5	6	7	8	9	10
Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10

To be completed by office staff:

Circle one: Initial / Re-eval / Discharge
Diagnosis:

Pain Scale Score: **Disability Scale Score:**	**Total Score:**

Scoring: Summate the scores and divide by the highest score possible. If an item is deemed not applicable no score is calculated. Multiply the total score by 100. The higher the score, the greater the impairment.