

NORTH COUNTY WATER & SPORTS THERAPY CENTER
 Frogs Club One/Carmel Mountain Ranch•12171 World Trade Drive•San Diego, CA 92128• (858) 217-2137

Patient Information Form

Name: (last) _____ (first) _____ (MI) _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Phone: _____

Employer (Name): _____ Work Phone: _____ (ext): _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Emergency Contact: _____ Day Phone: _____ Evening Phone: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____

Family Physician: _____ Phone: _____

Whom may we thank for referring you to? _____

Have you ever received physical therapy before? Yes No Where? _____

When? _____ For what diagnosis? _____

General Medical History

Do you now have or have you had any of the following?		Are you pregnant?	Yes/No
High blood pressure	Yes/No	Do you smoke?	Yes/No
Arthritis	Yes/No	Are you taking any medications?	Yes/No
Allergies	Yes/No	please list: _____	
Ulcers/stomach problems	Yes/No	_____	
History of seizures	Yes/No	_____	
Tuberculosis	Yes/No	Have you had any surgeries?	
Asthma/lung problems	Yes/No	please list (include type and date of surgery)	
Shortness of breath	Yes/No	_____	
Diabetes, Hypoglycemia	Yes/No	_____	
Neurological problems	Yes/No	_____	
Emotional/psychological problems	Yes/No	_____	
Heart Disease/problems	Yes/No	Comments: _____	
Pacemaker	Yes/No	_____	
Chest pain	Yes/No	_____	
Circulation problems	Yes/No	_____	
Dizziness, nausea	Yes/No	_____	
Skin problems	Yes/No	_____	
Kidney problems	Yes/No	What goals do you wish to achieve in physical therapy?	
Liver problems	Yes/No	_____	
Thyroid problems	Yes/No	_____	
Cancer	Yes/No	_____	
Repeated infections	Yes/No	_____	
Weight loss or gain	Yes/No	_____	
Osteoporosis	Yes/No		
Vision or hearing difficulties	Yes/No		
Sensitivity to heat or cold	Yes/No		
Any orthopedic problems	Yes/No		

Patient Signature: _____ Date Completed: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

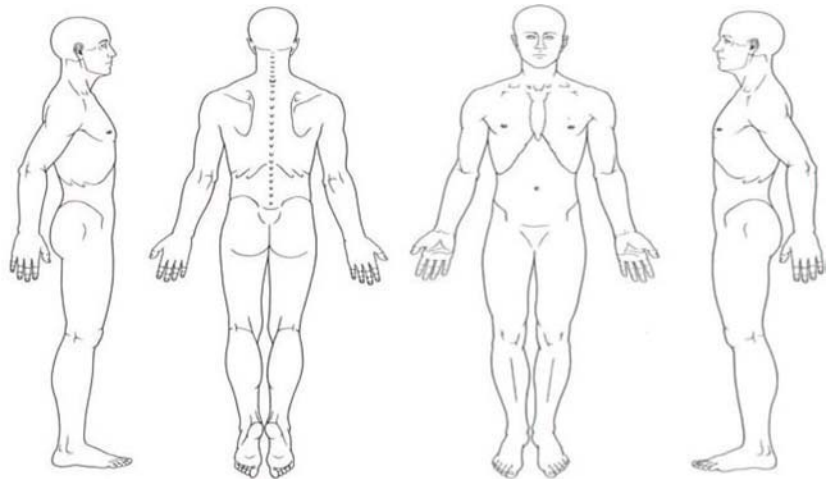
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

NORTH COUNTY WATER & SPORTS THERAPY CENTER

Frogs-Club One/Carmel Mountain Ranch 12171 World Trade Drive San Diego, CA 92128 (858)217-2137

BILLING PROCEDURES

- As a courtesy to our patients, we will bill your insurance company directly upon your authorization.
- If you choose not to assign insurance benefits to us, the full amount is due at the time of service.
- Most insurance plans cover a percentage of physical therapy; the patient is responsible for the remaining percentage at the time of service.
- Please inform us if you have a deductible that has not been fully paid so we can work together on a suitable payment arrangement.
- The patient and/or spouse are fully responsible for payment of the account. Any payments from the insurance carrier will be credited to the account.
- All accounts with an outstanding balance will receive a statement processed on the last business day of the calendar month.
- If you have difficulty paying after each visit, please let us know so we can work together on a suitable payment arrangement.
- As a courtesy to our patients, we call to verify what your insurance coverage will be; however, this is not a guarantee of payment or coverage.
- All necessary equipment for land and water therapy will be provided at no cost to the patient during his/her scheduled physical therapy appointment; however, any necessary equipment the patient will need for a home exercise program may be purchased at a discount by the patient. A receipt will be issued in order for the patient to bill his/her respective insurance company.
- As a courtesy to our patients, we file insurance claims with the primary insurance carrier; however, we cannot accept responsibility for collecting your insurance claims or for negotiating settlement on disputed claims.
- If you wish us to bill your insurance company directly, please sign the Benefits Assignment below.

DISCOUNTS

- We accept cash or checks (from local banks). A \$25.00 fee will be charged for returned checks. Cash patients receive a discounted rate.
- A swim pass is available for all physical therapy patients who need to use the pool as part of their “home” program. This pass is good for 20 visits and may be purchased at the Front Desk. The pass must be paid at the time of purchase. A receipt will be issued in order for the patient to bill their respective insurance carrier.

INTEREST

- All charges not paid in full within 30 days from the date they are rendered may be subject to a 2% interest charge per month (24% APR) on the unpaid balance. A \$15.00 rebilling fee will be added to all accounts that are 90 days past due.

**We require a 24 hour cancellation notice.
A treatment charge will be assessed for “No Shows”
And cancellations with less than 24 hours notice**

NOTE: Insurance will not cover cancellation and “No Show” fees.

AUTHORIZATIONS

I hereby authorize the release of medical information to my insurance carrier that may be necessary to process my claims.

I hereby authorize payment directly to this practice for the medical expense benefits otherwise payable to me.

I agree that if my insurance carrier does not pay for the services rendered unto me in full, I will be responsible to make full payment within 20 days of receipt of a statement for services.

In the event it is necessary to refer this account, I/we agree to pay all costs of collection, including but not limited to reasonable attorney fees, court costs and interest permitted by law.

I understand and acknowledge responsibility for all information explained to me in this document.

Patient Signature

Date

Parent/Guardian (If patient is under 18 years of age)

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at **North County Water and Sports Therapy Center**, because it can make the differences between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatments. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require **24 hours notice** in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a **\$40 charge for a cancellation without proper notice**. This charge will not be covered by insurance, but will have to be paid by you personally.
- For **Worker's Compensation and Personal Injury patients** documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, and educate you so you won't re-injure yourself, etc.

When you **don't show** as scheduled, **three people are hurt. You** because you don't get the treatment you need as prescribed by the doctor and/or PT; **the therapist** who now has a space in their schedule since the time was reserved for you personally; and **another patient** who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

Patient Signature

Date

HEALTH INFORMATION PRIVACY NOTICE
NORTH COUNTY WATER AND SPORTS THERAPY CENTER

I, the undersigned, have viewed and/or received a copy of the Health Information Privacy Notice that became effective April 14, 2003. This was made available to me either through the website, www.waterpt.com or was shown to me at North County Water & Sports Therapy Center.

Name: _____

Date: _____

Guardian: _____

Date: _____