NAME____ SOCIAL SECURITY #_______________________ M ____ F_____

ADDRESS ______________________________________ CITY ____________________ CA __________ ZIP _______________

HOME PHONE _____________________ CELL PHONE _____________________ WORK PHONE _______________________

DATE OF BIRTH ______________________ AGE _______ DRIVERS LICENSE # _____________________________________

EMPLOYER NAME ____

OCCUPATION/ POSITION ____

PERSON TO CONTACT IN CASE OF EMERGENCY ____

RELATIONSHIP___________________________________ PHONE # _______________________________________

MESA PHYSICAL THERAPY
PATIENT MEDICAL HISTORY FORM

(Federal regulations require that a medical history be included in each patient's medical record. Please print and fill in completely.)

Name____ Date_____/_____ /_____

Height ____ '_____" Weight ________ lbs Blood Pressure (if known) ______/_______

Have you ever had surgery? ____ Yes ____ No If yes, please describe and give dates: ______________________________

____

Have you had physical therapy for your present condition? ____Yes____No
If yes, please describe:

____

Have you ever received other treatments for your present condition? ____Yes____No

____

Are you presently taking any medication? _____Yes _____No If yes, please list: ______________________________

____

Do you have any metal anywhere in your body? ____Yes____No
Do you have a cardiac pacemaker? ____Yes____No
Are you pregnant? ____Yes____No
Do you have any trouble with vision? ____Yes____No
Do you have any trouble with hearing? ____Yes____No

Do you now have, or have you ever had any of the following:

Diabetes	____Yes____No	Stress	____Yes____No
High Blood Pressure	____Yes____No	Sensitive to heat/ice	____Yes____No
Heart Disease	____Yes____No	Allergies	____Yes____No
Heart Attack	____Yes____No	Hernia	____Yes____No
Headaches	____Yes____No	Broken Bones	____Yes____No
Kidney Problems	____Yes____No	Sprained Joints	____Yes____No
Nervous Disorders	____Yes____No	Seizures	____Yes____No
Circulation problems	____Yes____No	Dizzy Spells	____Yes____No
Back or neck pain	____Yes____No	Muscle aches or pain	____Yes____No

Please explain any **Yes** answers and give approximate dates: ____

____

Briefly describe the history of your present condition from onset to the present:
DATE OF INJURY: ____ /____ /_____

____

____

____

The above information is accurate and complete, to the best of my knowledge.

Signature ____ Date ____________________

FOR WORK INJURIES ONLY !

W/C JOB DESCRIPTION

NAME: ____ DATE: ___/___/___ DOI: ___ / ___/___

Occupation: ____

1. In terms of an 8 hour work day: (Circle number of hours for each activity)

Sit	(	1	2	3	4	5	6	7	8	)
Stand	(	1	2	3	4	5	6	7	8	)
Walk	(	1	2	3	4	5	6	7	8	)

2. On the job, I perform the following activities: (Check as many as apply)

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	_____	_____	_____	_____
Squat	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Reach above shoulders	_____	_____	_____	_____
Crouch	_____	_____	_____	_____
Kneel	_____	_____	_____	_____
Push/Pull	_____	_____	_____	_____
Maintain awkward posture	_____	_____	_____	_____
Balancing	_____	_____	_____	_____
3. On the job, I lift:				
Up to 10 pounds	_____	_____	_____	_____
11 to 24 pounds	_____	_____	_____	_____
25 to 34 pounds	_____	_____	_____	_____
35 to 50 pounds	_____	_____	_____	_____
51 to 74 pounds	_____	_____	_____	_____
75 to 100 pounds	_____	_____	_____	_____

4. Do you have to bend over while doing any lifting? Yes _____ No_____

5. Do you use your hands for repetitive movements, such as: (Please Check)

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATION
Right hand	_____	_____	_____
Left Hand	_____	_____	_____

6. Prior to this accident were you experiencing any similar physical complaints? _____Yes _____No

If yes, please explain:

____

____

7. In your own words, please describe accident:

____

____

____

IMPORTANT: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled. To protect your rights please fill out this form correctly and completely!

ACKNOWLEDGMENT OF NOTICE OF PRIVACY POLICIES

This is an acknowledgment that you have received the Notice of Privacy Policies. By signing this acknowledgment, you are not necessarily agreeing with all of our policies, only that you have been informed of these policies. This notice is clearly posted in the reception area and a copy is available upon request.

You may request modifications to the privacy policy by listing in the space provided below the specific entity(ies) with whom we may not share your information. We reserve the right to refuse treatment if we feel that your request would prevent us from providing adequate healthcare or being compensated for healthcare provided to you.

Please sign below:

____ ____________________

Patient's signature Date

You may not share my health information with the following:

________________________________ ______________________________________

Name Address

________________________________ ______________________________________

Name Address

MESA PHYSICAL THERAPY
PATIENT INFORMATION AND OFFICE POLICIES

OUR PURPOSE

Our purpose is to assist you and your physician in restoring your health and fitness and preventing a recurrence of your problem. This is best done in an atmosphere of congeniality, sincerity, and honesty. We encourage you to ask questions about your treatment. In our understanding of you and your goals, we can progress you towards our common goals of relieving your pain and improving your health.

APPOINTMENTS

The primary reason for appointments is to make efficient use of your time and our time. We make every attempt to provide your treatment on your scheduled time. If you need to cancel an appointment, as a courtesy to other patients, please call.

Appointments that are not cancelled by the end of the day before your scheduled appointment will result in a charge to you of $25.00. If you arrive early for an appointment we will try to see you early.
If you are late for an appointment, your treatment may be shortened or rescheduled.

PAYMENT POLICY

Our first objective is to accomplish your treatment goals. If the charges are a burden that would limit your attendance, please discuss this with the staff.

Co-payments are due prior to treatment. It is understood that under all circumstances, you assume final responsibility for your account. **You are responsible for contacting your insurance company to determine how they handle physical therapy charges.** We do our best to assist you with billing. However, the ultimate responsibility for payment rests with you. Our staff is pleased to bill your insurance company as a courtesy to you. For answers to additional questions regarding insurance billing, please call the Billing Office at (800) 929-7446 ext. 138.

WORKERS COMPENSATION

If you are injured as a result of an accident at work, you will not be expected to pay for any portion of the treatment. We accept the payment by your Workers Compensation insurance carrier as payment in full. We are required to notify your physician, employer and claims adjuster regarding any missed appointments. Three (3) missed appointments may result in discontinuation of further treatments.

MEDICARE

We are happy to provide our services to Medicare patients and **we accept assignment.** Medicare pays us 80% of their allowable amount for physical therapy service's provided. You are responsible for your annual medical deductible and the remaining 20% of the Medicare allowable charge (unless you have a Medicare supplemental policy). We "write-off" the difference between the Medicare allowable amount and our actual charges. We will also bill any co-insurance you may have after Medicare has determined the allowable payment.

I have read, understood, and agree abide by Mesa Physical Therapy Office Policies.

Please sign below:

Patient's signature: ______________________________ Date: ____________

Insured Signature: ______________________________ Date: ____________