Welcome to All Star Physical Therapy, Inc in order to serve you properly, we need the following information.
All information will be strictly confidential. (Please Print)

Patient Information

Patient Name:			Male / Female
Patient Date of Birth:_____/_____/_____	Patient Social Security Number:		
Street Address:	City:	State:	Zip:
Cell Phone:	Home Phone:		
I give All Star Physical Therapy permission to send appointment text reminders to the cell phone number I have provided. _____ (Initial)			
E-mail:			
Emergency Contact Name:	Phone:		
Referring Physician:	Primary Care Physician:		

If Patient is under 18 please complete:

Name of Responsible Party:	Relationship to Patient:	Responsible Party Date of Birth: _____/_____/_____

Primary Insurance

Insurance Company:	Policy Number:	
Name of Subscriber:	Relation to Patient:	Subscriber Date of Birth:_____/_____/_____

Secondary Insurance

Insurance Company:	Policy Number	
Name of Subscriber:	Relation to Patient:	Subscriber Date of Birth:_____/_____/_____
Will your visit today be covered through a 3rd party or motor vehicle accident? Yes / No (Must circle one)	Do you have an active workers compensation claim related to your visit today? Yes / No (Must circle one)	

Notice of Privacy

I hereby authorize the use or disclosure of my individually identifiable health information as described in the Notice of Privacy Practices for All Star Physical Therapy, Inc. A copy of the Notice of Privacy Practices will be provided upon my request.

Lifetime Assignment of Benefits / Information Release / Authorization to Treat

I authorize payment of medical benefits to All Star Physical Therapy, Inc. for any service furnished. I understand that I am finacially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company of its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims.
I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and or procedures.

Patient or Legal Guardian Signature:_____ Date_____/_____/_____

Thank you for choosing All Star Physical Therapy to provide your physical therapy needs. Please be aware of our cancellation, late, and no-show policies, initial each agreement, and sign your name below. We Appreciate you and will try to accommodate your needs.

Effective January 1, 2019:

I understand that I will be charged a **late cancellation fee of $25** if I fail to give *at least 24-hour notice* prior to cancelling my appointment. We Understand illness and emergencies.

Initial_____

I understand that I will be charged a **no-show fee of $25** if I fail to arrive to my appointment on time.

Initial_____

I understand that these charges are an **out of pocket expense** and that my insurance carrier will not cover these charges.

Initial_____

Patient's Name (print): _____

Patient's Signature: _____

Parent's Signature (if patient is a minor): _____

29645 Rancho California Rd. Suite 234 Temecula, CA 92591

Medical Information Release Form

HIPAA Release Form

Patient Name: _____ Date of Birth: ____/____/____

Release of Information

Privacy regulations require us to have a patient signed release form in order for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private healthcare information:

Name	Relationship	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

( ) Information is not to be released to anyone.

Messages

Please call ( ) My home ( ) My work ( ) My cell number

If unable to reach me:

( ) You may leave a detailed message

( ) Only leave a message asking me to return your call

NOTICE OF PRIVACY PRACTICES

I hereby authorize the use of disclosure of my individually identifiable health information as described in the Privacy Practices disclosure for All Star Physical Therapy, Inc.

A copy of the Notice of privacy practices will be provided upon my request.

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

This Release of Information will remain in effect until terminated by me in writing.

29645 Rancho California Rd., Ste. 234 Temecula, CA 92591
(951) 506-3001 Fax (951) 506-3002

PATIENT INSURANCE VERIFICATION FORM

Today's Date: _____ Initial Visit Date: _____ Verified by: _____

Patient Name: _____ **Date Of Birth:** _____

Insurance Company: _____ Tel: _____

Billing Address: _____

Subscriber Name (if not patient): _____ Subscriber DOB: _____

Ins ID#: _____ **Group #:** _____

Effective From: _____ To: _____ Plan Year / Calendar Year (Circle One)

Deductible: Individual: _____ Amt Met: _____ Family: _____ Amt Met: _____

Insurance Pays: _____ % Patient Responsibility: _____ % Co-Pay per Visit: $_____

Out of Pocket Maximum: Individual: _____ Amt Met: _____ Family: _____ Amt Met: _____

Visit / Dollar Limitations: _____ Visits / Dollars Used: _____

Authorization Required: Yes No From: _____ Tel: _____ Fax: _____

Spoke To / Ref. #: _____ (If online verification, attach Screen Print when possible)

The information above is a quote of benefits obtained from your insurance carrier and <u>not</u> a guarantee of payment. We recommend that you also verify benefits with your insurance carrier to resolve any questions you may have prior to treatment. Upon processing by your insurance carrier you will be responsible for non-covered expenses, regardless of the quote received.

It is our policy to collect all Copays and **<u>estimated</u>** deductibles and co-insurances at the time of service. Since we are only able to provide an estimate of your financial responsibility, you will receive statements upon processing of your claims by your insurance company. A summary of your financial responsibility is outlined below:

___ **Estimated** Deductible: $_____ per visit, for visits _____

___ **Estimated** Co-Insurance: $_____ per visit, for visits _____

___ Co-Pay: $_____ per visit

I have read and understood the Patient Insurance Verification Form and I understand that this is a quote of benefits and not a guarantee of payment from my Insurance Company.

Signed: _____ **Date:** _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Name: _____ **Relationship (if not patient):** _____

All Star Physical Therapy, Inc.
29645 Rancho California Rd., Ste. 234 Temecula, CA 92591 P: (951) 506-3001 F: (951) 506-3002

Brief Medical History

Patient Name: _____ Height: _____ Weight:_____ Age:_____Gender: M / F

How did you hurt yourself (MOI): _____

Diagnosis:_____Date of Injury (DOI): _____ Date of Surgery (DOS): _____

X-ray/MRI/special test Results: _____

Any past conditions/injury/surgery related to your current pain (PMH): Y / N Explain:_____

Are you working: Y / N What is your job title:_____# of years working: _____

What positions, movements, activities are difficult (circle): sitting / standing / bending / twisting kneeling / squatting /sit-to-stand walking / up/down stairs / reaching / gripping / grasping / lifting / carrying / other: _____
What does it feel like (circle): burning / sharp / dull / achy / throbbing / shooting / numbness / tingling / constant / intermittent

How intense is your pain at worst (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
How intense is your pain currently (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
How intense is your pain at best (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain

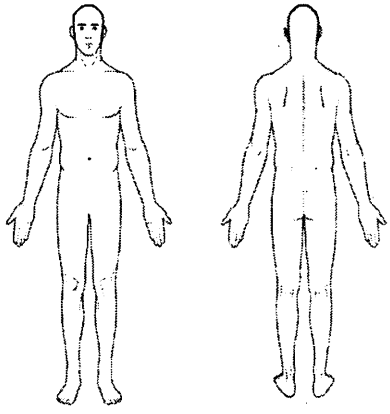
Fall History: Injury as a result of a fall in the past year? Y / N Two or more falls in the last year? Y / N

List of Medications

I do not take any medications ☐

What I take, and how much?	Why I take it?	When I take it?	How do I take it? (oral,topical)

Mark on the diagram where you have pain.



Do you now or have you ever had any of the following?

Alzheimer's	Yes	No	History of Cancer	Yes	No
Cardiovascular Disease	Yes	No	Huntington's	Yes	No
Cauda Equina Disease	Yes	No	Immunosuppression	Yes	No
Cerebral Vascular Accident	Yes	No	Lupus	Yes	No
Current Infection	Yes	No	Muscular Dystrophy	Yes	No
Diabetes Mellitus Type 1	Yes	No	Obesity	Yes	No
Diabetes Mellitus Type 2	Yes	No	Osteoarthritis	Yes	No
Fibromyalgia	Yes	No	Parkinson's	Yes	No
Fracture	Yes	No	Rheumatoid Arthritis	Yes	No
Suspected Fracture	Yes	No	Traumatic Brain Injury	Yes	No
High Blood Pressure	Yes	No	Pacemaker	Yes	No
MRSA	Yes	No	HIV	Yes	No

Other (please list below):

_____

_____

_____

If changes occur at any time during treatment, please notify your therapist.

_____ _____
Signature Date

Revised 12/16