New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information

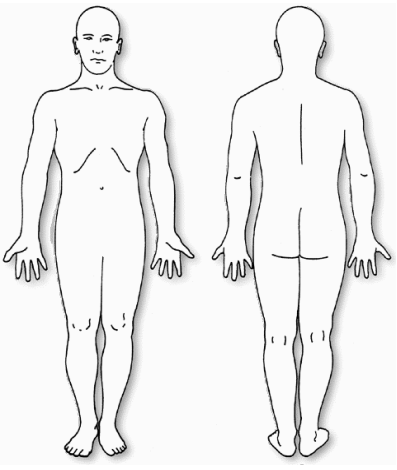
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit:						
Specialist Physician	Name:		Date of next visit:						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible .

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please X in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**		Level	Description
	At its worst		
	At its best		
	At present		
	Night		

New Patient Information Sheet

Patient Name: ***DOB:***

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (please describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurologic Problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine Headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fractures)		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If “Yes” – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

New Patient Information Sheet

Patient Name: ***DOB:***

Do you engage in regular exercise?		Yes	No
What type and how often?			
Are you able to exercise now?		Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?					Yes	No
Please Describe:						
In general, your lifestyle is:	1	2	3	4	5	
	Active		Average		Inactive	

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Patient Goals
Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that Physical Therapy San Pedro will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during the duration of treatment will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.

Patient/Parent/Guardian
Printed Name: _____Signature:_____Date:_____

In addition, photographs and video will be used as educational tools for website and social media purposes. By signing below, I consent to the use of these photographs in this manner.

Patient/Parent/Guardian
Printed Name: _____Signature:_____Date:_____

I do hereby agree and give my consent for Physical Therapy San Pedro to furnish care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian
Printed Name: _____Signature:_____Date:_____

Reassignment of Benefits

(Out-of-Network Insurance)

To Whom It May Concern:

I_____,allow assignment of benefits to be issued to the treating provider,

Dr. Janae Brown, PT, DPT.

I am aware that **Physical Therapy San Pedro** is a non- participating provider.

Please remit all check payments for services rendered directly to:

Dr. Ja'nae Brown, PT, DPT
481 W 6th Street
San Pedro, CA 90731

Kindly,

Patient Name: _____

Policy Holder Name: _____

Policy Holder Signature: _____

*ID #*_____

DOB: _____

Date: _____

Cancellation/No-Show Policy
(Insurance Pay)

All cancellations need to be made 24 hours prior to your scheduled appointment. ***If you do not show up for your appointment or cancel within 24 hours, you will be responsible to pay for 100% of the session.***

To avoid this cancellation fee, your appointment will be automatically adjusted from an in-person to Telehealth.

Telehealth Email: _____

Payment Policy

Your insurance benefits will be checked and verified prior to your initial treatment and you will be notified of your out of pocket expense. Treatment will be billed under your out of network physical therapy benefits and payment for the difference in coverage based on copayment and coinsurance responsibilities, in the form of cash, check or credit card, is due at the time of each visit. Because Dr. Ja'nae Brown is an out of network provider, your insurance may send payments directly to you, the patient. Please contact our office upon receipt of payment. You will be billed the full amount charged to your insurance company until payment is remitted to Dr. Ja'nae Brown.

I have read, understood and agree to the above policies:

Patient Name: _____

Patient/Guardian Signature: _____

Guardian Name: _____

Date: _____

Thank you for your cooperation and business.

DR. JA'NAE BROWN, PT, DPT
& Physical Therapy San Pedro

Patient Consent for Telehealth Services

PATIENT INFORMATION

First Name:		**MI:**	**Last Name:**
DOB:	**Age:**		**Today's Date:**

CONSENT FOR TELEHEALTH SERVICES *(Initial Below*

_____ I understand that I will be engaging in Telehealth with Physical Therapy San Pedro for my physical therapy evaluation and/or treatment sessions.

_____ It has been explained to me how the video conference technology will be used to conduct my physical therapy session and that there will not be direct patient/physical therapist contact due to the fact that I will not be in the same room as my physical therapist.

_____ I understand that there are potential limitations using this technology, including interruption, unauthorized access and technical difficulties. I understand that my physical therapist and/or I can discontinue the Telehealth session if it is felt that the videoconferencing connection is not adequate for the situation.

_____ I understand that my healthcare information may be shared with other Physical Therapy San Pedro staff for scheduling and billing purposes. The above-mentioned staff will maintain HIPAA confidentiality.

_____ The alternatives to a Telehealth session have been explained to me, and in choosing to participate in Telehealth session, I understand that some parts of the exam/therapy visit involving physical test/activities/ exercises may require the assistance of a caregiver/family member/ friend at my location at the direction of my physical therapist to conduct and /or gaurd me as the patient to ensure my safety.

_____ I understand that Physical Therapy San Pedro and my physical therapist responsibility of me, the patient, for a given session will conclude upon the termination of the video conference connection.

_____ I understand that Physical Therapy San Pedro will bill my session as usual to my insurance provider(s) as a physical therapy visit with the addition of using modifier codes to indicate my session was performed virtually using video conferencing technology.

_____ I have had a direct conversation with Physical Therapy San Pedro staff and /or my physical therapist, during which I had the opportunity to ask questions in regard to my physical therapy. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

Patient Consent for Telehealth Services

Patient Name: **DOB:**

I, THE PATIENT OR RESPONSIBLE PARTY OF THE PATIENT, HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS CONTAINED HEREIN: *(Initial Below)*

_____ *I acknowledge I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.*

_____ *I acknowledge I fully understand its contents including the risk and benefits of Telehealth physical therapy sessions*

Patient's Name

Patient/Guardian Signature

Legal Guardian Name/Association

Date