MONTCLAIR PHYSICAL THERAPY

510.339.2116 ■ Fax: 510.339.0647 ■ www.montclairpt.com ■ clinic@montclairpt.com
Two Oakland Offices: 473 34th St., Oakland, CA 94609 ■ 6116 Medau Pl., Oakland, CA 94611

CLIENT INFORMATION

Last Name:	First Name:	Middle Initial:

Date of Birth (MM–DD–YYYY):	Sex: ❑ Male ❑ Female ❑ _____		
Social Security No.: - -	Client Status: ❑ Single ❑ Married ❑ Other		
Address:	City:	State:	Zip:
Phone:	E-mail address:		
Cell Phone:			
❑ Reminder phone calls ❑ Reminder text messages ❑ Opt out from reminder notifications	❑ Yes, e-mail me newsletters and special offers. **Please give 24-hr notice if you are unable to make it to an appointment.**		

EMERGENCY CONTACT INFORMATION

Name:	Phone:
Relationship to patient:	

REFERRAL SOURCE

❑ Physician	❑ Friends or Family	❑ Website/Google	❑ Crossfit Competition
❑ Attorney	❑ Yelp	❑ First Tee Event	❑ _____

PRIMARY POLICY HOLDER INFORMATION (If under 18 years of age) ❑ Same as above

First & Last Name:	
Date of Birth (MM–DD–YYYY):	Phone:
Relationship to patient:	

Please notify our office if any of the above information changes during the course of your treatment.

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MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

LEGAL NAME: _____ PREFERRED NAME:_____

DOB:_____ PREFERRED PRONOUNS (circle): he/him she/her they/them Other: _____

HEIGHT:_____ ft. _____in. WEIGHT:_____ lbs. OCCUPATION:_____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? ☐ Yes ☐ No Any other relevant allergies:

Do you have:

METAL in your body? (other than teeth) ☐ Yes ☐ No
A pacemaker? ☐ Yes ☐ No
Abnormal vision problems? ☐ Yes ☐ No
Abnormal hearing problems? ☐ Yes ☐ No
Unusual weight gain or loss lately? ☐ Yes ☐ No
Recent loss of bowel or bladder control? ☐ Yes ☐ No

Have you EVER been diagnosed with:

☐ Arthritic conditions
☐ Asthma
☐ Blood clots
☐ Circulation problems
☐ Depression
☐ Diabetes
☐ Hepatitis
☐ Seizures
☐ High blood pressure
☐ Immune Deficiency Disease
☐ Multiple sclerosis
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Stomach ulcers
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Cancer. If YES what kind: _____
☐ Chemical dependency (i.e., alcoholism) _____
☐ Heart Problems. If YES what kind_____
☐ Kidney disease If YES what kind_____
☐ Other diagnoses:_____

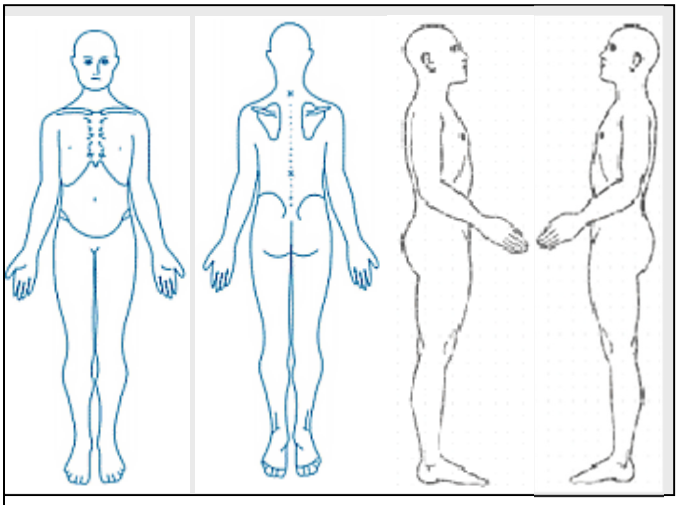
Which of the following medications have you taken in the last week? ☐ Aspirin ☐ Tylenol ☐ Herbals/Remedies
☐ Stomach ulcer medication ☐ Vitamins/Supplements
☐ Anti-inflammatories (Advil/Motrin/Ibuprofen etc)
☐ Others NOT prescribed by a physician _____

Please provide list of any other physician-prescribed medications you are currently taking (INCLUDE: name of drug, dosage, frequency, and administered route): _____

_____

_____

Please mark where you have pain.



Please provide a brief summary of your injury:

_____

_____

_____

_____

For your current condition, have you received any of the following? ☐ **Xray(s)** ☐ **CT scan** ☐ **MRI**

Have you ever had any surgeries? ☐ Yes ☐ No
If yes, please list the surgeries including the approximate date: _____

_____

_____

(For women only) Are you pregnant? ☐ Yes ☐ No
If yes, how many weeks?_____

I prefer: ☐ seeing information ☐ listening to information ☐ doing; participating; hands-on ☐ reading information

_____ _____ _____
Therapist Signature Client Name (Please print) Date

_____ _____ _____
Guardian Signature Date Client Signature

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FINANCIAL POLICY

Thank you for choosing Montclair Physical Therapy for your rehabilitation needs. We appreciate that you have entrusted us and we are committed to providing you with the best care possible. Please carefully read through the following financial information.

UPDATES: Please inform MPT anytime there is any change to your address, telephone or other contact information. If you are issued a new insurance card please bring it with you. If your insurance changes or discontinues mid-treatment, please notify us immediately so there is no delay in billing.

MEDICAL INSURANCE COVERAGE: Montclair Physical Therapy participates in most health plans, but not all. At the time of your initial visit we will attempt to verify your current insurance coverage. It is ultimately your responsibility to know your physical therapy benefits and all coverage is based on insurance coverage at the time of service. Rates are subject to change depending on your insurance policy.

CO-PAYMENTS AND DEDUCTIBLES: As part of our contractual agreement with your insurance company we must collect these fees directly from you. Often your annual deductible must be met before insurance will pay for physical therapy benefits. Co-payments/Deductible will be collected at time of service.
NOTE: Verification of Physical Therapy benefits is NOT a guarantee of payment.

AUTOMOBILE MEDICAL INSURANCE: We will bill your automobile insurance company for your treatment only when you have auto med-pay coverage with your policy. If you do not have auto med-pay, payment is due at the time of your service. We will provide you with documentation in order to facilitate reimbursement upon settlement of your case.

WORKERS COMPENSATION: We will bill your workers compensation carrier for your charges. In the event of claim denial or fraud, you will become financially responsible for all treatment charges.

CASH CUSTOMER: Please pay the balance in full at the time of service or upon receipt of invoice.

CANCELLATION POLICY: We require 24-HOUR notice for cancellation of a scheduled appointment. Failure to comply with this policy will result in a $25.00 charge. This charge will be billed to you directly. If there are more than three no shows/cancellations we will refer you back to the referring Physician.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical and, if applicable, government benefits to Montclair Physical Therapy. I assign all payments for physical therapy services to Montclair Physical Therapy. I agree that I am responsible for payment of my physical therapy invoices, whether or not my insurance company is paying them. I agree to pay for attorney's fees, legal fees, court costs, and any costs incurred in the collection of delinquent accounts. I agree to pay charges for appointments not cancelled 24 hours in advance. Payment is due upon receipt of invoice. A 12% per annum charge will be added to any invoice that has been left unpaid past sixty days. Failure to maintain these arrangements may result in the placement of your account with an agency for collection. Please sign and date this form to indicate that you understand and agree to all of the terms of the payment policy described above. Please let us know if you have any questions or concerns.

According to your insurance, you have a $_____ co-payment per visit.

Your annual deductible is $_____. You have a remaining deductible of $_____.

Your coinsurance is _____.

Signature of Responsible Party_____ Date _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information (PHI) by ***Montclair Physical Therapy, (MPT)*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***MPT.*** I understand that diagnosis or treatment of me by ***any licensed Physical Therapist (PT), or Physical Therapy Assistant (PTA) employed by MPT*** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***MPT*** is not required to agree to the restrictions that I may request. However, if ***MPT*** agrees to a restriction that I request, the restriction is binding on ***Montclair Physical Therapy and any licensed PT, or PTA employed by MPT.*** I have the right to revoke this consent, in writing, at any time, except to the extent that ***any licensed PT, or PTA employed by MPT*** has taken action in reliance on this consent.

My "protected health information" (PHI) refers to my health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health condition and identifies me (or there is a reasonable basis to believe the information may identify me). I certify all PHI shared with ***MPT*** is, to my best knowledge, correct and true and I understand my responsibility to inform ***MPT*** of any changes. I consent to the use of my PHI, especially my contact information regarding my treatment in conjunction with **MPT's** automated appointment and treatment notification system.

I understand I have a right to review ***MPT's*** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***MPT.*** This Notice of Privacy Practices also describes my rights and ***MPT*** duties with respect to my protected health information. **MPT** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient/Personal Representative **Name of Patient**

_____ _____

Name of Personal Representative & Relationship to Patient (if applicable) **Date**