Kristi Ayars, PT, DPT, PRPC, BCB-PMD, Owner
Kathleen Lopez, PT
9 Williamsburg Lane, Chico, CA 95926
530-891-4456 FAX 530-345-3375
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WWW.SIMPLYRESULTSPT.COM

Please complete the attached New Patient forms for Simply Results Physical Therapy. Once the forms have been completed, please fax, mail, or personally drop off at the Simply Results office. If the office is closed when you drop off your forms, you can place them through the mail slot and your forms will be attended to on the following business day.

After your forms have been received and reviewed, a physical therapist will contact you to get you into the schedule and answer any physical therapy related questions you may have. If you have any questions about the intake process, you can call the Simply Results office at any time, and we'll be more than happy to help.

Patient Information

(please print clearly)

Patient Name (full):_______________________________________Date:_________________

Address:_______________________________City:____________State:______Zip:________

Home ph:______________Work ph:____________________Other ph:____________________

Birth date:___________________Sex:_____________Marital Status:____________________

Occupation:____________Employer:_____________Employer Address:_________________

Email Address for Sending Home Programs:______________________________________

Who referred you to physical therapy?________________________Phone:________________

Primary Care Physician:____________________________________Phone:________________

Financially Responsible Person

Insured:________________________________Relationship:_____________________________

Address:_______________________________City:____________State:______Zip:________

Home phone:________________Work phone:________________Other phone:___________

Birth date:___________________Sex:_____________Marital Status:____________________

Occupation:____________Employer:_____________Employer Address:_________________

Other person to notify in case of emergency:___________________Phone:________________

If Medicare is your insurance, is yours: __regular Medicare OR __an "advantage" plan?

If Blue Shield is your insurance, is yours: __ an individual plan OR __through employer?

Assignment of Benefits and Release of Medical Information: I hereby authorize payment of medical benefits to SIMPLY RESULTS PHYSICAL THERAPY for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance within 60 days of service, and finance charges/fees will be assessed on overdue balances. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient/Insured Signature:___________________________Date:_____________

Medical History page 1 of 2

Date:______________

Patient Name: _______________________________Date of Birth: ____________/______/____________

Allergies	yes	no	Diabetes	yes	no	Metal Implants	yes	no
Anemia	yes	no	Dizzy spells	yes	no	MRSA	yes	no
Anxiety	yes	no	Emphysema/ Bronchitis	yes	no	Multiple Sclerosis	yes	no
Arthritis	yes	no	Fibromyalgia	yes	no	Muscular Disease	yes	no
Asthma	yes	no	Fractures	yes	no	Osteoporosis	yes	no
Autoimmune Disorder	yes	no	Gallbladder Problems	yes	no	Parkinson's Disease	yes	no
Cancer	yes	no	Headaches	yes	no	Rheumatoid Arthritis	yes	no
Cardiac Conditions	yes	no	Hearing Impairment	yes	no	Seizures	yes	no
Cardiac Pacemaker	yes	no	Hepatitis	yes	no	Smoking	yes	no
Chemical Dependency	yes	no	High Cholesterol	yes	no	Speech Problems	yes	no
Circulation Problems	yes	no	High/Low Blood Pressure	yes	no	Strokes	yes	no
COVID-19	yes	no	HIV/AIDS	yes	no	Thyroid Disease	yes	no
Currently Pregnant	yes	no	Incontinence	yes	no	Tuberculosis	yes	no
Depression	yes	no	Kidney Problems	yes	no	Vision Problems	yes	no

Women:

Number of Pregnancies:
Number of Vaginal Births:
Any episiotomies or tearing?:

Men:

Prostate cancer?:

Describe any other Conditions or Precautions:

Falls History: Injury as a result of a fall in the past year? YES NO Date of Fall: ______________________

Two or more falls in the last year? YES NO Date(s) of Falls:______________________

Please list any Home Falls Hazards you or others have identified:

Patient Name:________________ Date__________

Medical History page 2 of 2

You may submit a separate list, if you have one, for us to enter, but we are required to have the following information:

Surgical History:

Body region:	Surgery Type:	Month/Day/Year:
Body region:	Surgery Type:	Month/Day/Year:
Body region:	Surgery Type:	Month/Day/Year:
Body region:	Surgery Type:	Month/Day/Year:
Body region:	Surgery Type:	Month/Day/Year:

Please bring along a list of your current medications, instead of re-writing them here. We are required to have the following information:

Current Medications:

Drug:	Dosage:	Frequency:	Route:	Reason for taking:
Drug:	Dosage:	Frequency:	Route:	Reason for taking:
Drug:	Dosage:	Frequency:	Route:	Reason for taking:
Drug:	Dosage:	Frequency:	Route:	Reason for taking:
Drug:	Dosage:	Frequency:	Route:	Reason for taking:
Drug:	Dosage:	Frequency:	Route:	Reason for taking:

Please enter your height (__________ feet, ____________ inches), as well as your current weight (_____________ pounds.) Thank you.

In our office, we can take your Vitals: Blood Pressure ________________ Heart Rate ______________ O2 sats: ______________

PLEASE share in your words why you're here, and your goals for during and after the physical therapy process.

Thank you for your time.

9 WILLIAMSBURG LN, Chico, CA 95926 • Phone: 530-891-4456 • FAX: 530-345-3375

Please Initial(________) **Acknowledgment of Privacy Notice Receipt:**
For patient information, there is always in the waiting room a copy of the "Notice of Privacy Practices for Simply Results Physical Therapy, with an effective date of September 20, 2013" I understand that I may have a copy of the privacy notices at any time for my own files.

Please Initial(________) **Informed consent for evaluation and to start physical therapy treatment today, for the use of Simply Results Physical Therapy's courtesy billing service, and acknowledgement of my responsibilities as a patient:**

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy for me will be determined during the first visit and will be explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist so that treatment can be adjusted accordingly.

Alternatives: If I do not wish to participate in the therapy program, I will say so to the physical therapist. Also, I will continue to discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent attendance. I agree to cooperate with and carry out the home program assigned. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Please Initial(________) **Permission to leave message:** I authorize the routine practice of leaving a message on my answering machine as needed, and/or sending a text, and/or sending an email to confirm my appointments or to relay other information as needed to coordinate care.

Please Initial(________) **Cancellation Policy:** People on our waiting list are in pain and urgently need to be seen, and they also need time to make arrangements, so advanced notice is needed. On behalf of those in need of care, we respectfully request that you allow **ONE WEEK ADVANCE NOTICE** of any appointment changes to time or day.

Please Initial(________) **Health History Completed:** I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists at Simply Results Physical Therapy.

Please Initial(________) **Plan of Care Agreement:** My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, will all be explained by the PT as information is gathered. I am willing to ask questions about my care until my questions are answered to my understanding and satisfaction so I can consent to the recommended course of treatment. Returning for follow-up visits demonstrates agreement to the plan of care.

Please Initial(________) **Release of medical records/discuss with physician:** I authorize the release of my medical records to my physicians/primary care provider or insurance company. The PT is allowed to discuss my medical condition with my referring physician, with the permission I assign today. Also, other records, from any other facility where I have been treated, are authorized for release.

Please Initial(________) **Assignment of Benefits and Release of Medical Information:** I hereby authorize payment of medical benefits to SIMPLY RESULTS PHYSICAL THERAPY, INC for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance within 60 days of service, and finance charges/fees will be assessed on overdue balances. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature:______________________________ Patient Name:______________________________
(Please Print)

Signature of Parent or Guardian (If applicable)____

Witness Signature____________________________________ Date:__________________________

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NOTICE TO ALL PATIENTS:

On behalf of those in need of care,
we respectfully request that you allow
<u>ONE WEEK ADVANCE NOTICE</u>
of any appointment changes to time or day.

People on our waiting list are in pain and/or have an urgent need to be seen, and they also need time to make arrangements to get here.

I have read, understand and agree to the above terms:

______________________________ ________________
Patient Signature Date

____
Print Name

The fewer patients who cancel or attempt to reschedule with less than a week's notice, the more likely we will be able to continue without requiring any cancellation or no-show fee. Attending each visit will also speed you toward your recovery goals.

We are struggling for an effective way to express to you the importance of giving a week's notice, for your good and the good of all your fellow patients!