



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: _____ / _____ / _____
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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)
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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 financially 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.

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

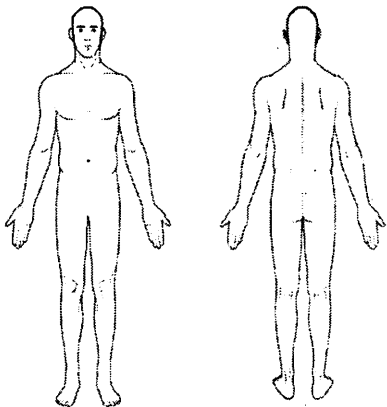
Fall History: Injury as a result of a fall in the past year? Y / N Two or more falls in the last year? Y / N

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