Vance Physical Therapy & Wellness, Inc.

NEW PATIENT QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial: _____
(Apellido) *(Su nombre)*

Address: _____ City: _____ State: _____ Zip: _____
(Dirección) *(Ciudad)* *(Estado)* *(Cremallera)*

Home No.: _____ Cell No.: _____ Employer No.: _____
(Número de casa) *(Número de celular)*

DOB: _____ Age: _____ Social Security No.: _____
(Fecha de nacimiento) *(Anos)* *(Seguridad social)*

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

E-mail: _____ Emergency Contact: _____
(Contacto de emergencia)

Phone No.: _____

Employer: _____ Occupation: _____ Retired? Yes / No

Primary Physician: _____ Phone No.: _____
(Medico)

Referring Physician: _____ Phone No.: _____

Auto Accident: ( ) Yes ( ) No Date of Injury: _____ Adjuster: _____
(Accidente de auto) *(Fecha de herida)* *(Ajustador)*

Work Related: ( ) Yes ( ) No Date of Injury: _____ Adjuster: _____
(Traborjo relacionado) *(Fecha de herida)* *(Ajustador)*

PRIMARY INSURANCE INFORMATION *(Seguro Primario)*

Name: _____ Phone No.: _____

PLCY/CLM No.: _____ GRP No.: _____

Name of Insured: _____ DOB: _____

SECONDARY INSURANCE INFORMATION *(Seguro Secundario)*

Name: _____ Phone No.: _____

PLCY/CLM No.: _____ GRP No.: _____

Name of Insured: _____ DOB: _____

YOUR PERSONAL PAST MEDICAL HISTORY

Please check the following symptoms and/or conditions that pertain to your past medical history:

- ☐ Anemia
- ☐ Angina
- ☐ Anxiety / Depression
- ☐ Arrhythmias
- ☐ Asthma
- ☐ BiPAP
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Artery Disease
- ☐ Clotting/Bleeding Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ CPAP
- ☐ Cystic Fibrosis
- ☐ Day Time Sleepiness
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Histocytosis
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Dysfunction
- ☐ Obstructive Sleep Apnea
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Reflux
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Seizures
- ☐ Sinusitis
- ☐ Stroke
- ☐ Systemic Lupus
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Weakness
- ☐ Wegener's Disease
- ☐ Other _____

PAST SURGERIES
(Cirugias Previas)

Year *(Ano)*	**Procedure** *(Procedimiento)*

MEDICATIONS
(Medicaments)

Please list all medications that you are currently taking, including vitamins, supplemental herbs, and over-the counter medications.

	Medication *(Medicament)*	**Dosage** *(Dosificacion)*	**Frequency** *(Frecuencia)*	**Route of Administration**
Example:	Zantac	150 mg.	Twice per day	oral

If we have not provided enough room to note your medication, kindly provide us with a list.
Reviewed by:

PATIENT'S VERIFICATION

RELEASE OF MEDICAL INFORMATION: I authorize the release of medical and billing information about myself, responsible party listed above or dependents to my referring doctor and/or primary care provider, insurance company (ies) listed above or any facility or future takers that Vance Physical Therapy and Wellness, Inc. may ref me to.

NOTICE OF PRIVACY: By signing this form, you are acknowledging receipt of Vance Physical Therapy and Wellness, Inc. Notice of Privacy Practices.

Medicare: If you have Medicare, by signing this consent, you are authorizing the payment of Medicare benefits to be made to Vance Physical Therapy & Wellness, Inc. for any services furnished to you by our clinic.

BILLING POLICY: Vance Physical Therapy & Wellness, Inc., will verify benefits and bill your insurance company (ies) as a courtesy to you. However, services or procedures denied by your insurance company will be your responsibility. By signing below you agree to pay for services provided by Vance Physical Therapy and Wellness, Inc. to either, you, your spouse, children or dependent (s). All co-pays/co-insurance portions that are not paid for by your insurance company (ies), are due upon receipt of patient statement. You also agree if any patient balance exceeding 90 days will be charge an interest charge of 8% per month if balance is not paid in full, or if you fail to contact our business office to set up plan arrangements. If your auto insurance or worker's comp insurance denies the claim, the balance due is your responsibility. Vance Physical Therapy and Wellness, Inc. does not accept letters of protection or attorney lien's. ***Co-pays/Co-insurance portions are due at the time services are rendered, unless arrangements have been established*** I authorize the above listed insurance company(ies) to make payment directly to Vance Physical Therapy & Wellness, Inc. for services rendered.

Patient's Signature: _____ **Date:**_____

Important Policies

We strive to provide you with the best personalized care available. To make this possible we adhere to set of very Important policies. Please read them carefully and indicate your agreement by signing at the bottom.

Late Policy "10- minutes" *(Tarde diez Minutos)*

Being late by more than 10 minutes will require you to reschedule. If we allow a patient in for treatment later than 10 minutes from their appointed time, it will overlap and compromise the care of another patient. We do not allow this. How would you like it if it were you?

24-Hour Advance Notice "$20 fee" *(Veinte cuatro horas de anticipación)*

If you wish to change or cancel and appointment, we require a minimum 24-hour advance notice. Anything less Than that will result in a $20 fee applied to your account.

It cost us over $35 to offer you a single appointment. But we don't charge you that. We merely charge $20, not To make money, but to act as a deterrent from making last minute changes.

Advance notice allows someone else (who needs it) time to reserve the appointment in place of you. Please be Courteous and responsible. Thank you.

BILLING POLICY *(Facturacion)*

Vance Physical Therapy & Wellness Inc. will verify benefits and bill your insurance company (ise) as a courtesy to you. However, serv ices or procedures denied by your insurance company will be your responsibility. Co-pay/Co-insurance portions are due at the time services are rendered, unless arrangements have been established.

No-Shows Are Bad *(Si no se presenta es malo)*

If you fail to show for an appointment without notice, all future appointments you have scheduled will be Removed. You may reschedule appointments again on a "first come, first serve basis."

I have carefully read and agree to all the above policies. In the event such policies are broken, I agree to the Consequences set forth.

Signed _____ Date _____

Diagnostic Testing Screening Tool

Patient Name: _____ Date:_____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what diagnostic tests* might be appropriate for you.

Please check all that apply:

	Low Back and Radiating Pain		Neck Pain and Radiating Pain
	Numbness, Tingling or Burning Sensation in the Legs or Feet		Numbness, Tingling or Burning Sensation in the Arms or Hands
	Weakness in the Legs or Arms		Loss of sensation in Hands / Feet
	You have Diabetes or Neuropathy		Daily alcohol 3 glasses or more
	Thyroid Dysfunction		Muscle Disease / Muscle Cramping
	Tendinitis / Bursitis / Arthritis		Shoulder Pain or Instability
	Elbow Pain or Instability		Wrist-Hand Pain or Instability
	Hip or Knee Pain or Instability		Ankle – Foot Pain or Instability
	Blurred Vision		Hearing Problems
	Dizziness or Vertigo		Headaches
	Unsteady gait		History of falls due to dizziness
	Hypertension		Hypotension
	Anything else you consider important:		

Patient Signature: _____

*Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.

Falls Efficacy Scale

Name:_____ Date:_____

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity:	**Score:** 1 = very confident 10 = not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off of the toilet	
Total Score	

VANCE Physical Therapy & Wellness Inc.

Statement of Privacy Notice

Effective February 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (559) 592-7117. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (559) 592-7117. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

❑I have read the Privacy Notice and understand my rights contained in the notice.

VANCE Physical Therapy & Wellness Inc.

_____ _____

Signature Date

By way of my signature, I provide Vance Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice