DEMETRIOS
SPINE AND WELLNESS
PHYSICAL THERAPY

25377 Madison Ave Ste A-104
Murrieta, CA 92562
Phone: (951) 696- 0677
Fax: (951) 696- 0688

Welcome to Demetrios Spine and Wellness Physical Therapy. In order to serve you properly, we need the following information. All information will be strictly confidential (Please Print).

Patient Information

Last Name: _____ First Name: _____ Preferred Pronouns: _____

Nickname: _____ Date of Birth: _____ Age: _____ Sex (at birth): ☐ Male ☐ Female

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Minor Spouse's/Parent's Name: _____

Address: _____ City, State: _____ Zip: _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work Reminders: ☐ Text ☐ Voicemail ☐ None

Secondary Phone: _____ ☐ Cell ☐ Home ☐ Work Reminders: ☐ Text ☐ Voicemail ☐ None

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? _____

General Information

Referring Physician's Name: _____

Phone: _____ Fax: _____ Address: _____

Diagnosis: _____ Area of Body: _____

Primary Care Physician's Name: _____

Phone: _____ Fax: _____ Address: _____

Employer's Name (If Worker's Comp): _____

Phone: _____ Address: _____

Attorney's Name (if Lien or Auto): _____

Phone: _____ Fax: _____ Address: _____

Insurance Information: For automobile accidents which are non-work related, please provide your auto insurance information. For work injury, please provide employer's worker compensation insurance carrier information. For other types of accidents, please provide your personal health insurance information.

Insurance Type: ☐ Private Health ☐ Worker's Comp ☐ Auto ☐ Other (Specify): _____

Primary Insurance Company: _____

Subscriber Name: _____

Relation to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Self

Subscriber Date of Birth: _____

Subscriber SS#: _____

Policy Number: _____

Group Number: _____

Insurance Phone: _____

Secondary Insurance Company: _____

Subscriber Name: _____

Relation to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Self

Subscriber Date of Birth: _____

Subscriber SS#: _____

Policy Number: _____

Group Number: _____

Insurance Phone: _____

Medical Health History

Are you working? ☐ Y ☐ N What is your occupation? _____ Is this problem affecting your work? ☐ Y ☐ N

Do you have a history of falls?..... ☐ Y ☐ N If yes, when? _____

Do you smoke?..... ☐ Y ☐ N If yes, # of packs/day? _____

Are you pregnant?..... ☐ Y ☐ N

Have you had unexplained weight loss?..... ☐ Y ☐ N

Are you currently taking corticosteroids?.....☐ Y ☐ N

Do you use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ None ☐ Other _____

Height: _____

Weight: _____ lbs **Required for Medicare and some private insurances**

Handedness: ☐ Left ☐ Right

What type of exercise are you currently doing? _____

Have you in the past or are you currently experiencing any of the following?

☐ Cane
☐ Balance Problems
☐ Blood Clots
☐ Bowel or Bladder Dysfunction
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Circulatory Problems
☐ COPD
☐ Depression
☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Dizzy Spells
☐ Drug/Alcohol Dependency
☐ Fibromyalgia
☐ Fracture or Suspected Fracture
☐ Hearing Problems
☐ High Blood Pressure
☐ History of Cancer
☐ History of Stroke
☐ Huntington's
☐ Immunosuppression
☐ Intestinal Problems
☐ Kidney Problems
☐ Lupus
☐ Memory Loss
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's
☐ Past or Current Infection
☐ Pelvic Pain
☐ Pulmonary Problems
☐ Rheumatoid Arthritis
☐ Seizures
☐ (taking) Steroids/ Hydrocortisone
☐ Sudden Urges to Urinate
☐ Traumatic Brain Injury
☐ Vertigo
☐ Visual Problems

☐ Past surgical history/dates: _____

_____

☐ Other medical history: _____

_____

_____

What test(s) have you had for your symptoms and when? (Specify on what body part & date received)

☐ X-ray: _____ ☐ CT Scan: _____

☐ MRI: _____ ☐ Other: _____

List any allergies (including medication allergies): _____

_____

List all prescriptions or over the counter medications you are CURRENTLY taking (or provide list):

_____

Main Complaint/Primary Concern: _____

_____

How did your symptoms start: _____

_____

Is this a(n): ☐ Injury ☐ Work injury ☐ Auto Accident ☐ Surgery* ☐ Gradual Onset (check one)

Date of Injury/surgery/onset: _____/_____/_____

*What type of surgery was performed: _____

Were you hospitalized for this problem? ☐ Yes ☐ No Dates: _____

Have you been treated for this problem in the past? ☐ Yes ☐ No Dates: _____

Have you received Home Health Care? ☐ Yes ☐ No Dates: _____

Who have you seen for your symptoms?

☐ No one ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other _____

Please indicate where you have pain or other symptoms.

Please indicate your pain at its **WORST:**

0	1	2	3	4	5	6	7	8	9	10

No pain Moderate pain High pain

Please indicate your pain **CURRENTLY:**

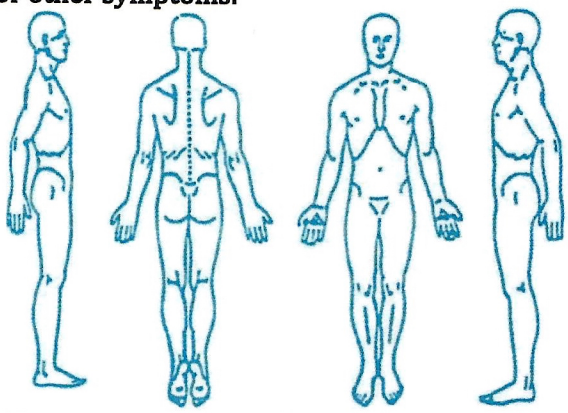
0	1	2	3	4	5	6	7	8	9	10

No pain Moderate pain High pain

Please indicate your pain at its **BEST:**

0	1	2	3	4	5	6	7	8	9	10

No pain Moderate pain High painπ



(Please mark where you have pain/symptoms)

My pain is increased by: _____

My pain is decreased by: _____

What describes the nature of your symptoms:

☐ Burning
☐ Sharp
☐ Dull
☐ Throbbing
☐ Achy
☐ Numbness
☐ Shooting
☐ Tingling
☐ Constantly
☐ Intermittently
☐ Getting Better
☐ Not Changing
☐ Getting Worse
☐ _____

Current Medical Providers

Do you have an appointment to return to your referring doctor? ☐ Yes ☐ No

If so, when is your next appointment? _____

Please list all physicians whose care you are under. Please include their information as follows:

Doctor's Name _____ Phone Number _____
First Last

Address _____
Street City Zip Code

Doctor's Name _____ Phone Number _____
First Last

Address _____
Street City Zip Code

Doctor's Name _____ Phone Number _____
First Last

Address _____
Street City Zip Code

Waiver of Liability Release Form

In consideration of being allowed membership in Demetrios Spine and Wellness Physical Therapy, the undersigned acknowledges and agrees that:

1. The risk of injury from utilizing this facility may be significant, including by not limited to the potential for permanent paralysis and death, serious injury to internal organs, musculoskeletal injuries and possible impairment to my general health and well-being.

2. I knowingly and freely assume all responsibility for any risk of loss, property damage or personal injury that may be sustained by me, or any loss or damage to property owned by me, as a result of my use of Demetrios Spine and Wellness Physical Therapy.

3. I further agree to released and hold harmless Demetrios Spine and Wellness Physical Therapy from all claims and liabilities of any type whatsoever and for damages to, loss or destruction of any property or injury, sickness or death, which may result from my participation in Demetrios Spine and Wellness Physical Therapy activities.

4. I willingly agree to comply with Demetrios Spine and Wellness Physical Therapy rules and regulations.

5. I acknowledge that I am in good physical condition and do not know of any condition or reason that I should not participate in Demetrios Spine and Wellness Physical Therapy activities.

6. I understand that a medical examination/screening to assure myself of physical fitness is desirable, that obtaining such an examination is my own responsibility.

In signing this release, I acknowledge and represent that I read the foregoing Waiver of Liability Form, understand it and sign it voluntarily as my own free act and deed. I am at least eighteen (18) years of age and fully competent. If under 18 my parent or guardian shall also sign.

Member (Over 18)

_____ _____ _____

Print Name **Signature** **Date**

_____/_____/_____ _____

DOB **Phone #**

_____

Email

_____ _____ _____

Emergency Contact **Relationship** **Phone #**

For participants of Minority Age (Under 18)
This is to certify that I, as **parent/guardian** with legal responsibility for this participant, do consent and agree to his/her release as provided above.

_____ _____ _____

Print Name **Parent/Guardian Signature** **Date**

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Last Name: _____ **First:** _____ **DOB:** _____

Address: _____ **APT/STE:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ Primary Yes__ No__

Cell Phone: _____ Primary Yes__ No__ **Email:** _____

Appointment Alert Notifications: Text __ VM __ Email __ (choose one only)

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone:_____

PATIENT WORK INFORMATION

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Ext.: _____ Occupation: _____

REASON FOR VISIT

Diagnosis: _____ **Date of Injury:** _____

Referring Doctor: _____ **Doctor's Phone:** _____

Authorization to Pay

DEMETRIOS SPINE AND WELLNESS PHYSICAL THERAPY

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to DEMETRIOS SPINE AND WELLNESS PHYSICAL THERAPY and I understand that I am financially responsible for non-covered services and any amount not paid by my insurance. I also authorize Demetrios Spine and Wellness to release any information to process this claim.

SIGNED _____ **DATE** _____

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NOTICE OF PRIVACY PRACTICES

We protect the privacy of our patient's health information and practice standards with regards to our internal policies and procedures, as required by law. This privacy statement explains your rights, our legal duties and our privacy practices.

Your Health Information

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

We collect, use, and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization to confirm insurance coverage, for medical billing, and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, other health care provides or health plans, to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information, in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you with medical file management or for the coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Require by Law: Information by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or require by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights

Under regulations that have been in effect since April 14, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive and additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Declaration of Privacy of Health Information

All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

I authorize that the results of any assessments or records given to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provide treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plant or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors, and administrators. Restrictions requested by client:

Patient Signature_____ Date_____

Demetrios Spine and Wellness
Physical Therapy
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Demetrios Spine and Wellness Physical Therapy Cancellation Policy

Thank you for choosing Demetrios Spine and Wellness Physical Therapy as your therapy provider. We are dedicated in assisting you with your therapy goals. It is important for you to attend your schedules appointments to achieve the goals your health care provider and your therapist have established for you.

When you must cancel a scheduled appointment, please call Demetrios Spine and Wellness Physical Therapy as soon as possible 951-574-7776. For your convenience you can leave a message after our regular business hours and on holidays.

- **If you fail to give 24 hours notice, you will be charged a $55 late cancellation fee. There are no exceptions to this policy.**
- **We cannot accept patients for treatment that are more than 15 minutes late. After 15 minutes, the appointment will be considered a late cancellation and the $55 fee will be charged.**
- **If you CANCEL TWICE CONSECTIVELY with <u>less than 24 hour</u> notice all appointments will be deleted. *Future appointments may only be made day of, provided that an appointment is available.**
- **If you NO SHOW twice all remaining appointments will be deleted and your physician will be notified. *It will be necessary to contact the director of Demetrios Spine and Wellness Physical Therapy for approval to schedule future appointments.**

Your insurance does not cover charges for late or no-show cancellations; it is the patient's responsibility.

We require a credit card on fire for all patients and clients.

- **I have read the Demetrios Spine and Wellness Physical Therapy Cancellation Policy and I understand its contents _____**
- **A credit or debit card must be "on file". I understand the credit card will automatically be charged for missed appointments _____**

MC/VISA/Other _____ exp _____

Select: Patient _____ Parent _____ Legal Guardian _____Other _____

Printed Name _____

Address _____

City _____ STATE _____ ZIP CODE _____

Signature _____ Date _____

DEMETRIOS
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PHYSICAL THERAPY

CONSENT FORM

Therapy is a patient care service provide in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability.

The purpose of therapy is to treat disease, injury, and disability by evaluation, examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided you might be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure, and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. You therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. Demetrios Spine and Wellness Physical Therapy reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read and received a copy of the consent form and authorize release of medical information to appropriate third parties.

Patient's Signature _____ Date _____