Sims Physical Therapy, Inc.

2530 Professional Parkway-Santa Maria, CA 93455 (805)928-4465 Fax(805)928-7935

PATIENT INFORMATION FORM (Please Complete All Entries)

Minor or Dependent Patient: Name (Last - First - Middle)	Sex M F	Date of Birth / /	Age	Social Security Number
Adult Patient:Name(Last-First-Middle) or Parent or Guardian Mr. Ms. Mrs.	Sex M F	Date of Birth / /	Age	Social Security Number
Mailing Address	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated			
City	Driver's License No.			
State / Zip		Home Phone No. ( )		Cell Phone No. ( )
Name of Employer	Occupation		Work Phone No. ( )	
Employer's Address (Street - City - State - Zip)				
Name of Spouse (Last - First - Middle)	Age	Date of Birth / /	Social Security No.	
Spouse's Employer	Occupation		Spouse's Work Phone No. ( )	
Nearest Relative Not Living With You			Relative's Phone No. ( )	
In Case of Emergency, Notify			Emergency Contact's Phone No. ( )	
Type of Injury ☐ Work Related ☐Auto Accident ☐ Student Accident ☐Other ____________________	Date of Injury		Have You Been A Patient In Our Office ? ☐Yes ☐No Year(If Yes)___________	
Family Members Who Have Been Patients	Referred By		Family Physician	

INSURANCE INFORMATION

Primary Insurance Name	Name of Insured	
Insured's Employer	Insured's Date of Birth	Relationship to Insured
Secondary Insurance Name	Name of Insured	
Insured's Employer	Insured's Date of Birth	Relationship to Insured

I have read and fully understand Sims Physical Therapy, Inc.'s Notice of Information Practices posted in the lobby. I understand that Sims Physical Therapy, Inc.may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is unsed and disclosed for treatment, payment and adminstrative operations if I notify the practice. I also understand Sims Physical Therapy, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge use and disclosure of my personal health information for purposes as noted in Sims Physical Therapy, Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I request payment by Medicare/Other Insurance company benefits be made either to me or on my behalf to Sims Physical Therapy, Inc. for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand is is mandatory to notify Sims Physical Therapy, Inc. of any insurance or benefit changes immediately. Physical or Occupational therapy may be painful.

Signature: ____ Date: ____________________

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Occupational Therapy Intake

1. What is the reason you were referred to Occupational Therapy? ______________________________________
____

2. What other treatments have been tried: ____

3. Did it help? □ Yes □ No If yes, how did it help? ____

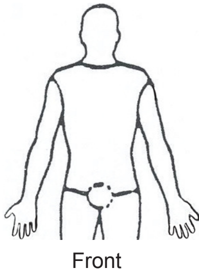
4. When is your next appointment with the referring physician? __/___/___

5. What is your occupation? ____________________
Describe the physical requirements of that job:____
____

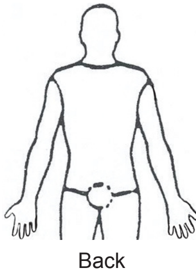
6. What support do you have from your family/significant other/employer __________________________________
____

7. Onset of Problem:____________________ Describe what happened: ________________________
____ ____

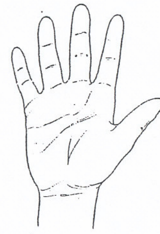
8. Mark areas of pain:

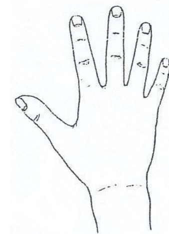


Front



Back





9. What activities increase your pain? ____

10. How are you able to relieve the pain? ____

11. Functional limitations:

Feeding self	☐ limited	☐Very limited	☐Unable to do	Cutting	☐ limited	☐Very limited	☐Unable to do
Dressing	☐ limited	☐Very limited	☐Unable to do	Fasteners	☐ limited	☐Very limited	☐Unable to do
Grooming	☐ limited	☐Very limited	☐Unable to do	Bathing	☐ limited	☐Very limited	☐Unable to do
Driving	☐ limited	☐Very limited	☐Unable to do	Work	☐ limited	☐Very limited	☐Unable to do

14. Have you ever had any of the following problems?

___ Heart Disease ___Kidney problems ___Fractures ___Bleeding Disorders
___ Diabetes ___Mental health ___Stroke ___Hepatitis C
___ Circulatory problems ___Cancer ___High Blood Pressure

15. List any past surgeries: ____

16. Are you pregnant? ☐ Yes ☐ No

17. What benefits do you expect from Occupational Therapy?____
____
____

Patient's Signature: ____________________________________

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to treatment.

All patients must complete out information and insurance form before seeing the therapist

WE ACCEPT CASH and CHECKS
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL

REGARDING INSURANCE
We may accept assignment of insurance benefits. The balance is your responsibility whether or not your insurance pays. We cannot bill your insurance company unless you give us your information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contact. In the event we do not accept assignment of benefits we require that you be pre-approved on a payment plan. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your extended plan of payment and payment in full will be expected. Payment is required before 30 days on your extended plan of payment. If after 90 days no payment has been received an administrative charge of 10% will be assessed to your account. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance.

Regarding insurance plans where we are a participating provider. Al co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not providers, refer to above paragraph.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance arbitrary determination of usual and customary rates.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by your insurance company and an approved payment plan has been signed.

Thank you for understanding our financial policy. Please let us know if your have any questions or concerns.

________________________________ ________ ________________________________ ________
Signature of Patient or Responsible Party Date Signature of Co-Responsible Party Date