101 Hodencamp Road, Suite #102
Thousand Oaks, CA, 91360
Phone: 805-496-9944 Fax: 805-496-9945

Patient Information

Thank you for choosing Advanced Physical Therapy and Sports Medicine. Please complete the following forms. Please Print Clearly.

Patient's Name: _____ Today's Date: _____/_____/_____

Address:_____ City:_____St: ____Zip:_____

SSN (Billing purposes): _____ Sex: M F Date of Birth: _____/_____/_____

Driver's License Number: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Email Address: _____

Occupation:_____ Employer: _____

Injured Body Part: _____ Date of Injury/Surgery: _____/_____/_____

Referring Doctor: _____ How did you hear about us?_____

Are you under 18 and/or a dependent on a guardian's insurance (circle one)? Yes No

If Yes, Guardian's Name: _____

Emergency Contact: _____ Phone: ( ) _____

Insurance/Billing Information

Please Provide Advanced Physical Therapy and Sports Medicine with your Primary and Secondary health insurance information and a copy of your insurance card(s).

Name of Insured: _____ _____ Relationship to Patient: _____

Is this a work related injury? Yes No **If Yes,** Worker's Compensation Claim:_____

Worker's Compensation Adjuster: _____ Adjuster Contact #:( )_____

If No, Primary Insurance Provider: _____ Policy Number: _____

Group Number: _____ Services Contact Number: ( ) _____

Secondary Insurance Provider: _____ Policy Number: _____

Group Number: _____ Services Contact Number: ( ) _____

I certify the above information is true to the best of my knowledge. I will notify you of any changes in the above information.

Patient's Signature:_____ Date: _____/_____/_____

Advanced Physical Therapy and Sports Medicine (APTSM) Policies

Carefully read the following information. If you have any questions, please discuss them with us.

Payment Policy: As a courtesy, Advanced Physical Therapy and Sports Medicine (APTSM) has verified your insurance benefits and we will bill your primary insurance carrier for you. Please remember that you are ultimately responsible for payment of all services rendered. Your portion of payment: Private pay, co-payment, co-insurance and/or deductible payments are required at time of service for each visit.

I have read the above policy and I acknowledge that I am ultimately responsible for payment of all services rendered.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

Credit Card on File

It is the policy of APTSM to require an imprint of a credit card as security for payment of future charges.

Cardholder name: _____ Credit Card Type: _____

Account Number: _____ Expiration Date: _____/_____/_____

I hereby authorize APTSM to charge for the agreed amount for services rendered on the verification of benefits form. This information will be kept private and secured by APTSM.

Signature of Authorized Cardholder: _____ Date: _____/_____/_____

Note- if you prefer, for privacy reasons an imprint can be taken at time of first visit.

Consent to Treat/Authorization/Assignment of Benefits

I give consent to APTSM to provide physical therapy services to me, my child or my legal ward.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

I hereby authorize APTSM to furnish to my insurance carrier(s) any and all requested information concerning my health. I also authorize my insurance carrier(s) to pay APTSM (Eric Honbo, PT or Cody Jones, PT) directly for any services rendered.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

Cancellation Policy/ Privacy Policy

Please give us 24 Hours notice if you are unable to keep your scheduled appointment. APTSM does not accept same day cancellation. _____(initial)

I have received a copy of APTSM's Health Insurance Privacy Policy. _____(initial).

ADVANCED
PHYSICAL THERAPY & SPORTS MEDICINE

General Health Questionnaire

Have you recently noticed any of the following symptoms? Indicate Yes or No:

Yes____ No____ Fever/Chills/Sweats
Yes____ No____ Weight Gain/ Loss
Yes____ No____ Malaise (feeling unwell)
Yes____ No____ Unusual Fatigue
Yes____ No____ Nausea/Vomiting
Yes____ No____ Numbness/Tingling
Yes____ No____ Weakness
Yes____ No____ Dizzy/ Loss of Consciousness
Yes____ No____ Chest Pain/Palpitations
Yes____ No____ Swelling in Feet or Hands
Yes____ No____ Difficulty Breathing
Yes____ No____ Cough/Blood in phlegm
Yes____ No____ Wheezing
Yes____ No____ Difficulty Swallowing
Yes____ No____ Heartburn/Indigestion
Yes____ No____ Bowel/Bladder changes
Yes____ No____ Difficulty Urinating (start/stop)
Yes____ No____ Urine frequency Changes

Have you ever been diagnosed as having any of the following conditions?

Yes____ No____ Heart Problems
Yes____ No____ High Blood Pressure
Yes____ No____ Circulation Problems
Yes____ No____ Rheumatoid Arthritis
Yes____ No____ Other Arthritic Conditions
Yes____ No____ Stroke
Yes____ No____ Lung Disease
Yes____ No____ Asthma
Yes____ No____ Pacemaker
Yes____ No____ Diabetes
Yes____ No____ Tuberculosis
Yes____ No____ Cancer
Yes____ No____ Osteoporosis
Yes____ No____ Depression
Yes____ No____ Epilepsy/Seizures
Yes____ No____ Muscular Disease/Disorder
Yes____ No____ Hepatitis
Yes____ No____ Thyroid Problems
Yes____ No____ Current pregnancy
Yes____ No____ Other_____

List ALL Surgeries, Medical Conditions or Injuries for which you have been treated:

_____**Date**_____
_____**Date**_____
_____**Date**_____

List ALL Medications you are currently taking (pills, injections, inhalers, vitamins, etc):

_____
_____
_____

The above information is true and complete to the best of my knowledge. I hereby authorize Advanced Physical Therapy and Sports Medicine to release any and all information concerning my care to my insurance carrier. I further authorize direct payment to Advanced Physical Therapy and Sports Medicine and I understand that I am financially responsible for all charges not covered by my insurance carrier.

Name (please print): _____

Signature: _____ **Date:** _____/_____/_____
(Patient or Guardian)