RMS Physical Therapy
41715 Winchester Rd., Ste. 202
Temecula, CA 92590
T: 951-296-0788 F: 951-296-3661

PATIENT INFORMATION
INFORMATION TO BE FILLED OUT COMPLETELY

Patient Name: _____ Date **of Birth**: _____ **Sex:** ☐ Male ☐ Female

Address: _____**APT#**_____ **City/State/Zip**: _____

Home Phone: _____ **Cell Phone**: _____ SSN: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**: _____

Referring Physician: _____ **Date Last Seen Physician**: _____

How did you hear about our clinic? _____

INSURANCE INFORMATION **PPO** **Self Pay** *(circle one)*

Insurance Carrier Name: _____ **Member ID/Group Number** _____

Name of Subscriber _____ **Subscriber DOB:** _____

Relationship to Subscriber: _____ **Subscriber Address**

By affixing my signature below, I hereby state that the information which I have provided is correct to the best of my knowledge. I am responsible for my medical fees; including amounts not covered by insurance carrier. I authorize Responsible Medical Solutions (RMS) Physical Therapy Department to release any medical information to my insurance company. I authorize direct payment of medical benefits for my services to RMS. I give permission to RMS Physical Therapy to render the proposed examination and treatment. I acknowledge that I have read and reviewed the Notice of Privacy and the Informed Consent and I am aware that I have the right to obtain a paper copy of these notices upon request.

Signature_____ **Date:** _____

Printed Name if other than patient: _____ **Relationship** (If not patient) _____

IN OFFICE USE ONLY

Referring Physician: _____ Date of Prescription: _____ Duration/Frequency_____

Insurance Billing Address: _____ **Tele: _____ Network Status: PPO NON PPO**

Effective Date: _____ to _____ Plan Year/ Calendar Year (circle one) **Individual Ded _____/_____ Family Ded_____/_____**

Insurance Pays: _____% Patient Pays _____% Copay Per Office Visit: $_____ Visit Max_____ Visits Used: _____

Out of Pocket Max: Individual **_____/_____ Family _____/_____ Primary Coverage YES NO**

Authorization Requires: YES NO From: _____ Tele: _____ Fax: _____

CSR Name and Reference#:_____Verified By: _____**Date**:_____

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Name: _____ **Date:** ___/___/____
Your therapist will review this questionnaire to better address your needs. If you do not understand a question, please leave it unanswered.

1. Please describe what you are being treated for:_____

_____

2. When did your symptoms start? _____

3. What caused your symptoms? _____

4. Did you have Surgery? Yes / No Date of Surgery:___/___/_____

5. How often do you experience your symptoms during the day? *(Please circle one)*

Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

6. What symptoms are you having? *(Please circle all that apply)*

Swelling Loss of Motion Weakness Pain
Stiffness Loss of Balance Numbness/Tingling Other: _____

7. Describe your pain: *(Please circle all that apply)*

Sharp Dull Ache Radiating
Burning Stabbing Pins & Needles

8. Are you worse in the: *(Please circle all that apply)*

Morning Afternoon Evening Doesn't Matter

9. Which Activities increase your symptoms? (i.e. sitting, walking, driving, etc…)

_____

10. What decreases your symptoms? (i.e. ice, rest, lying on side, etc…)

_____

11. Do your symptoms interrupt your sleep? YES NO

12. How are your symptoms changing? (*Please circle one)* Getting Better No Change Getting Worse

13. Who have you seen for this injury/symptoms? *(Please circle all that apply)*

No One Medical Doctor Physical Therapist Chiropractor
Massage Therapist Acupuncturist Other: _____

14. What diagnostic Testing have you had?

X-rays MRI CT Scan EMG Other_____
Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

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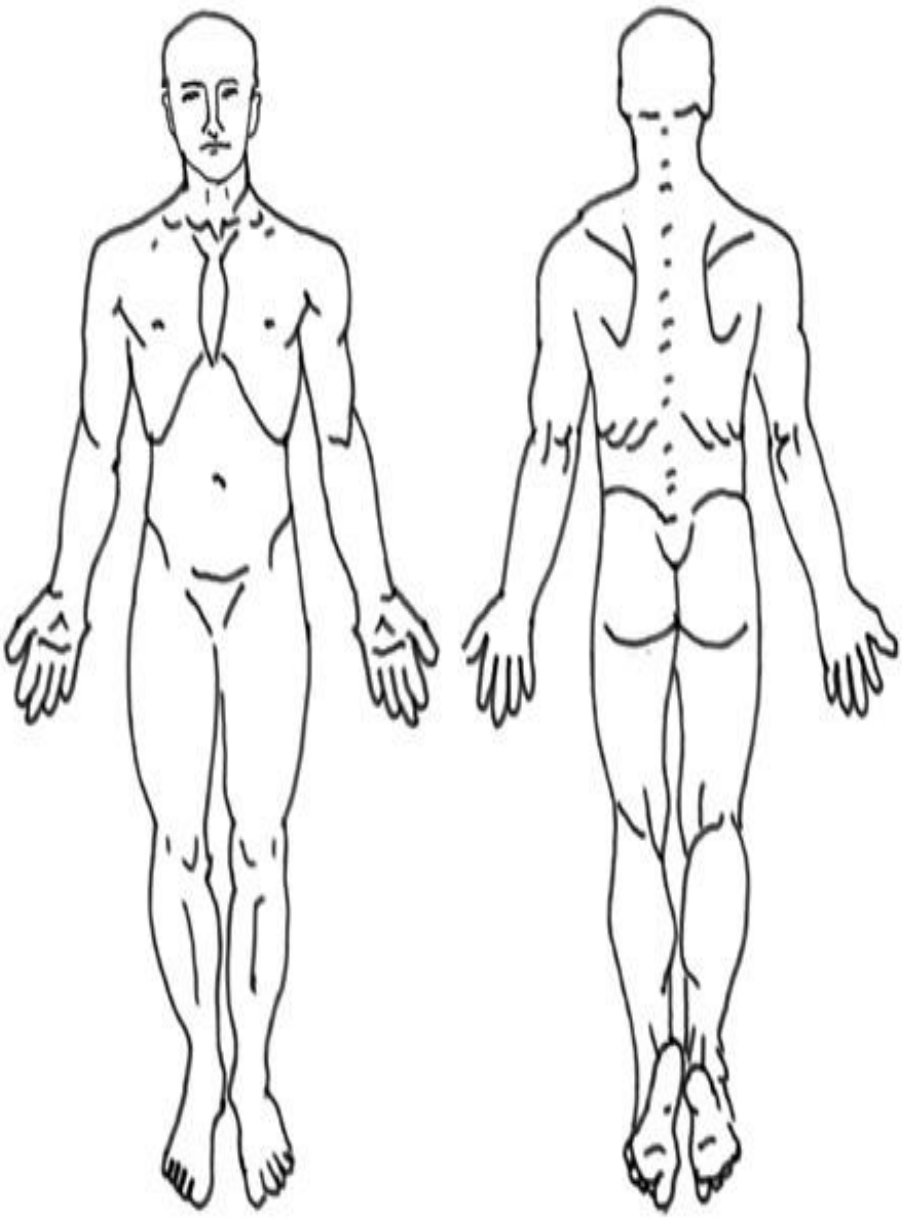
Ache	AAA
Numbness	OOO
Pins and Needles	_ _ _
Burning	XXX
Stabbing	///



15. On a scale of 1 to 10 (ten being the worst pain you ever felt) what is your current level of pain?_____

16. Since your surgery / Procedure, are you now:? __ Better __ Worse __ The same

Name: _____ Date: ___/___/____

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17. Do you have any of the following medical conditions? *(Please circle all that apply and explain yes answers below)*

_High Blood Pressure	_Osteoporosis/Osteopenia	_Night Sweats
_Heart Disease	_Rheumatoid Arthritis	_Muscle Cramps
_Pace Maker	_Cancer	_Circulation problems
_Diabetes	_Recent weight loss/gain	_Dizziness
_Allergies/skin sensitivity	_Pulmonary Disease	_Depression
_Sensitivity to hear or cold	_Autoimmune Disorders	_Bowel/Bladder Incontinence
_Seizures	_Liver Disease	_Anxiety/Panic Attacks
_Headaches	_Spleen Disorder	_Muscle Tenderness/Weakness
_Gout	_Gallbladder disorder	_Swollen Legs or Feet
_Nervous Disorders	_Pancreatic Disorder	_General Fatigue
_Stroke/CVA	_Kidney Disorders	_Nausea/Vomiting
_History of Falls	_Thyroid Disease	_Stomach Ulcers
_Balance problems	_Pregnant	_indigestion/heart burn
_Vision Problems	_Past Surgeries	_Other_____
_Hearing Problems	_Recent Fever	_None
_Metal Implants	_Shortness of breath	
_Osteoarthritis	_Easy Bruising	

Explanation: _____

_____

18. Please list any medications with their dosages which you are currently taking: _____

_____

19. Please list any activities/sports and their duration which you are currently involved in: _____

_____

20. What goals/activities would you like to achieve with physical therapy? _____

_____

21. Is there anything else which you would like to tell your physical therapist? _____

_____

Fall Risk Assessment

Have you fallen in the last 12 Months? YES NO **If So, how many times?** _____

Did the fall result in an injury? YES NO **What was the injury?** _____

Why are falls occurring? _____

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Notice of Privacy Practices:

_____(INITIAL) As required by privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA) our office has visibly posted notice which describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. By initialing/signing this form, you are acknowledging that you have read and understand the literature provided. A written copy of the notice can be provided to you by request.

Patient Financial Responsibility Policy:

_____ (INITIAL) We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office.

1. **Private Insurance**: Professional services rendered to you or your dependents by RMS are your sole financial responsibility. RMS will bill you insurance as a courtesy, but you are ultimately responsible for payment for your treatment. If we are a contracted provider with your insurance, you will be held liable for co-pays, co-insurances, deductibles, and non-covered items. You are required to pay your co-payment at the time of service. Any additional balances left after your insurance processes your claim will be reflected on a monthly billing statement. Any unpaid charges on an account for 75 days are subject to collection action.

2. **Cash Patients**: If you do not have insurance, you will be expected to pay for treatment at the time of service.

Cancellation/No Show Policy:

_____ (INITIAL) Responsible Medical Solutions Physical Therapy wants to provide the best possible care for our patients. Attending appointments is a necessary part of the treatment process. Please provide a 24 hour cancellation notice before your scheduled appointment. Otherwise, there will be a $25.00 cancellation/no show fee billed to your account. This is a non-covered charge by your insurance company and will be collected at your next visit.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____