Patient Personal Information

Name: _____
Last First Middle

Street Address / P.O. Box : _____
City State Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ Marital Status: S / M / D / W / Other

Social Security #: _____-_____-_____ Drivers License # _____

Employer's Name: _____ Work Phone: ( ) _____

Employer Address: _____
City State Zip

Referring Physician : _____ Injury : _____ Injury Date: _____

* IF PATIENT IS UNDER THE AGE OF 18, PLEASE FILL OUT THIS SECTION *

Responsible Party: _____ Date of Birth: ____/____/____

Relationship to Patient: _____ Social Security #: _____-_____-_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Street Address / P.O. Box : _____
City State Zip

INSURANCE INFORMATION

PRIMARY Insurance Carrier's Name : _____

Name of Insured: _____ Date of Birth: ____/____/____

Insurance ID # : _____ Group #: _____

SECONDARY Insurance Carrier's Name : _____

Name of Insured: _____ Date of Birth: ____/____/____

Insurance ID # : _____ Group #: _____

EMERGENCY CONTACT (Not living at Same Address)

Name: _____ Relationship: _____

Street Address / P.O. Box : _____
City State Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____

CONSENT FOR MEDICAL TREATMENT

Signed: _____ Date: _____

ADULT: I hereby authorize **Maxim Rehab Inc** and all persons acting as agents thereof, as well as all medical personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me.

Signed: _____ Date: _____

MINOR: I, as a parent/guardian of the above named minor, hereby authorize **Maxim Rehab Inc** to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to said minor.

MAXIM
PHYSICAL THERAPY

HIPAA – CONSENT FORM

Maxim Rehab Inc. has always exercised safeguards, pertaining to your personal health information. Now, with the new HIPAA regulations in effect, we are to provide each patient With our specific safeguards spelled out in writing and have you sign a Consent that you have reviewed and understand the Notice of Health Information Practices.

- I understand that Maxim Rehab Inc., reserves the right to change and/or revise their Notice of Practices and those changes/revisions will be posted in their lobby for me to review.
- I understand that Maxim Rehab Inc., may convey messages or phone calls, while I am here as a patient, if and when another calls to check on me. However, a full release to anyone regarding my "specific" health information requires me to personally sign a Medical Records Release (Authorization). Please request this form if you want to authorize us to speak with a spouse, relative or any other person.
- While at the clinic, inadvertently I may hear another person's name when they are called to the back office, I may accidentally see a computer screen or chart, or additionally, I may overhear Physical Therapists or Staff speaking of another patient. I understand and respect that this information is "Protected Health Information" and I am requested by Maxim Rehab Inc., to not retain or disclose of this information.
- I have the right to request restrictions on the use and disclosure of my Protected Health Information to carry out treatment, payment or healthcare operation 45CRF164.522.
- I have the right to revoke, in writing, my Consent to use or disclose health information except to the extent that action has already been taken.
- I may revoke or refuse to sign the Consent form. However, by doing so, Maxim Rehab Inc., is NOT required to see and/or treat me, as a patient.

Patient Name (Please Print): _____

_____ _____

Patient Signature (or Legal Representative) Date

_____ _____

Maxim Rehab Inc., Rep-Witness "Notice" Effective Date

For Office use ONLY – Requests: _____

_____

_____

_____ _____ _____

Maxim Rehab Inc., Rep – Signature Title Date

___ Accepted ___ Denied

MAXIM
PHYSICAL THERAPY

Financial Payment Policy

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Here are the answers to the most commonly asked questions:

1. FINANCIAL OBLIGATIONS: As a courtesy to our patients, we will bill your health insurance company for any treatments performed. If after 90 days your insurance has not paid, we will request payment from you. Because the therapist's service is provided directly to you and not to the insurance company, you are **ultimately** responsible for payment of the account.

2. REGARDING INSURANCE: Any co-payments, co-insurance amounts or annual deductible amounts required by your insurance must be paid at the time of service. We accept cash, personal checks, Visa, Mastercard and Discover. Because we are the provider of service, benefits are assigned to and will be paid to us by the insurance company.

3. SPECIAL NEEDS: We understand you may have a special financial need. It may be necessary to set up a payment plan for the expected amount of the treatment costs. If this situation is necessary for you or your family, please bring this to our attention as soon as possible.

Thank you for taking the time to read this policy statement. We hope it answers some questions for you. If you have additional questions please let us know. Regular communication with our office helps prevent misunderstandings about your bill. We prefer to maintain your account in our office instead of sending it to an outside agency.

WE ARE HERE TO HELP!

I acknowledge full financial responsibility for services rendered by Maxim Physical Therapy. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance such as co-pays, co-coinsurance and deductibles at the time of service. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my account.

Signed_____ Date_____

REDDING
2321 Court Street • Redding, CA 96001
(530) 242-8480 • fax (530) 242-8485

PALO CEDRO
9461 Deschutes Road #4 • Palo Cedro, CA 96073
(530) 547-5478 • fax (530) 547-2747

MAXIM PHYSICAL THERAPY

Date: _____

PATIENT INTAKE SHEET / EVALUATION

Name: _____ **Age:** _____ **Male / Female**

Current Condition: _____

When did symptoms start? _____

- ☐ 1 week ago
- ☐ Greater than 1 week but less than 4 weeks
- ☐ Greater than 1 month but less than 3 months
- ☐ Greater than 3 months

Mechanism of Injury / Current condition:

- ☐ Fall
- ☐ Carrying object
- ☐ Movement
- ☐ Motor Vehicle Accident
- ☐ Work Injury
- ☐ Sports
- ☐ Overuse
- ☐ Other: _____

Primary concern / complaint:

- ☐ Loss of function
- ☐ Pain
- ☐ Difficulty with Average daily activities
- ☐ Other: _____

Current pain level as it relates to you current condition:

Pain Scale 0 - 10 (0 = No pain, 10 = extreme pain):

Worst (0 1 2 3 4 5 6 7 8 9 10) circle one
Current (0 1 2 3 4 5 6 7 8 9 10) circle one
Best (0 1 2 3 4 5 6 7 8 9 10) circle one
Is your pain Constant or intermittent (circle one)

Aggravating factors:

- ☐ Lying on back
- ☐ Lying on side
- ☐ Lying on stomach
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Stairs
- ☐ Dressing
- ☐ Hygiene
- ☐ Lift / Carry
- ☐ Reaching
- ☐ Other: _____

Function prior to current condition:

- ☐ Independent
- ☐ Needed some assistance
- ☐ Needed moderate assistance
- ☐ Unable to function

Pain Relief with any of the following?:

- ☐ Sitting
- ☐ Lying down
- ☐ Walking
- ☐ Standing
- ☐ Heat/Ice
- ☐ Medication
- ☐ Other - Massage, Acupuncture, etc..

Restrictions:

Difficult / Unable to

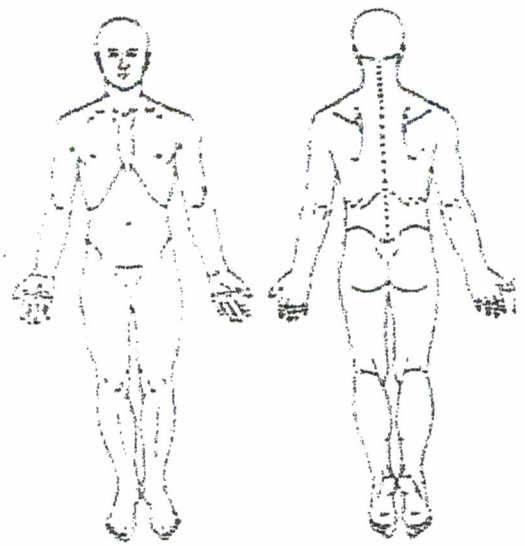
- ☐ Lift
- ☐ Sit for a period of: _____ minutes.
- ☐ Stand for a period of: _____ minutes.
- ☐ Walk for a period of: _____ minutes.
- ☐ Sleep for a period of: _____ hours.

Patient (your) goals:

- ☐ Increase range of motion
- ☐ Increase strength
- ☐ Decrease pain
- ☐ Return to prior function
- ☐ other _____

Current condition only!

Please mark where you hurt.



Previous injury to this area?

- ☐ Yes
- ☐ No

When? _____

Previous Therapy for this area?

- ☐ Yes
- ☐ No

When? _____

Overall general health?

- ☐ Good
- ☐ Fair
- ☐ Poor

Please list all Surgeries and Dates

_____

_____

_____

_____

_____

Medical History:

- ☐ Diabetes
- ☐ Heart issues / pacemaker
- ☐ Stroke
- ☐ High blood pressure
- ☐ Osteoarthritis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Cancer _____
- ☐ Other _____

Recent medical tests (on current condition)

- ☐ X-ray
- ☐ MRI
- ☐ CT-Scan
- ☐ Injections
- ☐ Nerve conduction test
- ☐ Bone scan

Where were these tests performed?:

_____

Medication Log - Prescriptions, Over-the-counters, herbals, and vitamin/mineral/dietary (nutritional supplements)

Patient Name:					Date	
Name of Medication	Date Started	Dosage	Frequency	Route of Admission	Prescribing Physician	Physician Phone Number

** This form is mandatory per 2013 Medicare guidelines **