TAG PHYSICAL THERAPY
111 Penn Street
El Segundo, CA 90245
(310) 426-9570 Fax (310) 426-9572

Date: ______________________________ Referring Doctor: ______________________________

PLEASE PRINT CLEARLY Home Phone: ______________________________

First Name: __________________________ Cell Phone: ______________________________

Last Name: __________________________ Birth Date: ______________________________

Address: __________________________ Social Security #: ______________________________

City, St., Zip:____ Sex: _____ Age: ____

Single_______ Married _______ Widowed _______ Separated _______ Divorced ______

Employer: _________________________ Occupation: ______________________________

Address: __________________________ Work Phone: ______________________________

City, St., Zip: _______________________ Drivers License #: ______________________________

Date last worked: ____________________ Has your employment terminated? __________________

Name of spouse or legal guardian: ____

Employer: __________________________ Birth Date: ______________________________

Address: __________________________ Work Phone: ______________________________

City, St., Zip: ________________________ Social Security #: ______________________________

May we leave voicemail messages regarding your appointments at the following?

Home: Yes_____ No: _____ Work: Yes:_____ No: _____ Cell: Yes:_____ No: _____

How did you learn of our practice? ____

Type of Payment? Insurance ______ Cash ______ Workers Comp ______

Is condition due to one of the following? : Work Related: ____ Auto Accident: ____

Other; Please Describe: ______________________________________

Insurance Carrier: ______________________ Date of Accident: ______________________________

Address: __________________________ Adjuster: ______________________________

City, St., Zip: ________________________ Phone #: ______________________________

PATIENT HISTORY

Please completely fill out the following questions. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Name: ____Date:_____________________

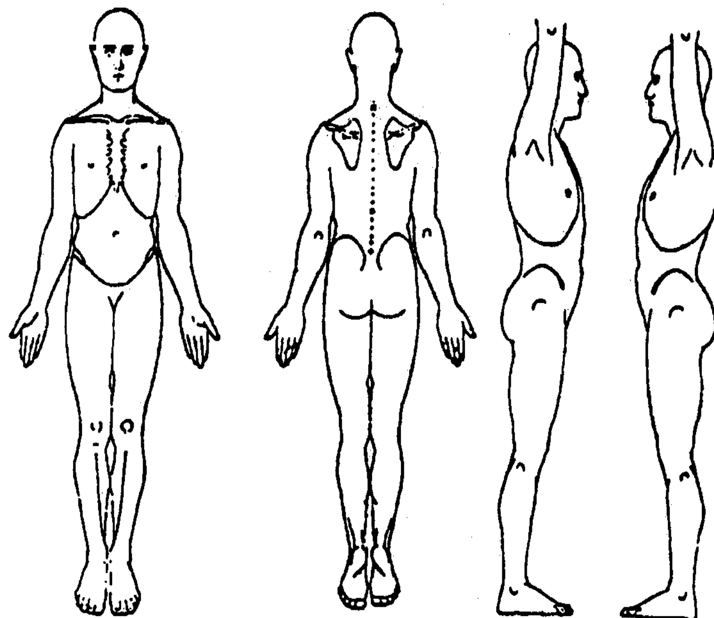
Birthdate:________________________________ Occupation:____________________________

Date of Injury or Onset of complaint(s):____
____

Briefly describe how you were injured or how complaints began (i.e. after tennis, bending....):
____
____

Where is your pain / injury located
____

Please use the drawings to indicate the location of your pain/injury.



List all over-the-counter and prescription medications you are currently taking for any reason: (include pills, injections, skin patch, etc.
____
____
____

If you have any metal or other implants in your body, please describe where they are:
____
____

Have you had any treatment for this condition? Yes ___ No____

If yes, please describe:____

Please check any of the following diagnostic studies completed for this condition:

☐ X-Rays ☐ Electromyography (EMG)

☐ MRI ☐ Computed Tomagraphy (CT Scan)

☐ Other

Have you ever been diagnosed with any of the following: (Circle Yes or No for each item)

YES NO Cancer If Yes, please describe: ____

YES NO Heart Attack

YES NO Other Heart Condition, If YES, please describe: ______________________________

YES	NO	Pacemaker	YES	NO	Kidney Disease
YES	NO	High Blood Pressure	YES	NO	Anemia
YES	NO	Respiratory Problems	YES	NO	Epilepsy
YES	NO	Asthma	YES	NO	Eye / Vision Problem
YES	NO	Emphysema	YES	NO	Emotional / Psychological Problems
YES	NO	Thyroid Problems	YES	NO	Sleep Problems
YES	NO	Diabetes	YES	NO	Headaches
YES	NO	Multiple Sclerosis	YES	NO	Hepatitis
YES	NO	Rheumatoid Arthritis	YES	NO	Tuberculosis
YES	NO	Other Arthritic Conditions	YES	NO	Osteoporosis
YES	NO	Stroke	YES	NO	Pregnant or think you might be.
YES	NO	Deep Vein Thrombosis (blood clot)	YES	NO	HIV
YES	NO	Other			

If YES, please describe: ____

Please list any surgeries or other conditions for which you have been hospitalized, include the approximate date and the reason for the surgery or hospitalization.

Date	Surgery / Hospitalization	Reason

Do you Smoke tobacco? Yes ☐ No ☐ If Yes, how much per day? __________________

What are your goals for Physical therapy? ______________________________________

____

____

TAG Physical Therapy Office Policies

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for TAG Physical Therapy to provide physical therapy care and treatment necessary and proper in evaluating and treating my physical condition.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize TAG Physical Therapy to treat the minor patient named in the attached consent form while I am not present.

Benefit Assignment/Release of Information: I hereby assign all medical benefits to which I am responsible to TAG Physical Therapy. I hereby authorize TAG Physical Therapy to release all information necessary, including medical records, to secure payment.

Workers' Compensation Claims: If I claim Workers' Compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered.

Cancellation and No-Show Policy: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $50.00.

____

Patient Signature Date

TAG Physical Therapy Financial Policy

As a courtesy to you, we bill your insurance carrier once each week and make every reasonable effort to assist you in expediting insurance payment. You are responsible for your bill and ultimately responsible for making your insurance carrier release payment. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you.

If any payment is made directly to you by the insurance carrier for services billed by us, you recognize an obligation to promptly remit the payment to TAG Physical Therapy.

Flat co-pays are due at the time of service. You will be billed if you have a co-insurance amount.

If formal collections procedures become necessary, you will be responsible for additional costs incurred.

I have read the above information and understand that I am solely responsible for the payment of my account.

____

Patient Signature (if minor, signature of parent/guardian) Date

TAG PHYSICAL THERAPY
NOTICE OF PATIENT INFORMATION PRACTICES

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

TAG PHYSICAL THERAPY'S LEGAL DUTY

TAG Physical Therapy is required is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

TAG Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, TAG Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

TAG Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, TAG Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

TAG Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. TAG Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that TAG Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our owner(s) at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on TAG Physical Therapy's health information practices, or if you have a complaint, please contact the following:

TAG PHYSICAL THERAPY
111 Penn Street, El Segundo, CA 90245
CATHY TARTE or MINDY GARVEY
(310) 426-9570 (310) 426-9572 Fax
May 1, 2006

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand TAG Physical Therapy's Notice of Information Practices. I understand that TAG Physical Therapy 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 if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I also understand that TAG Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in TAG Physical Therapy'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

____
Patient Name

___________________________ ______________________________________
Signature Signature of Parent/Guardian
(If patient is a minor)

____
Date