EVERGREEN PHYSICAL THERAPY

111 SOUTH HUDSON AVE PASADENA, CA 91101
Phone (626) 683 - 8536 Fax (626) 683 - 8236
www.EvergreenPT.net

PATIENT REGISTRATION

Patient's Name ______________________ Date of Birth ___/___/_____

Guardian (If minor) ______________________ Relationship __________

Patient's Address ______________________________

City ______________ State __________ Zip __________

Cell Phone ______________ Home Phone ______________

Email Address ______________________________

I would like to receive appointment reminders via ☐ Email ☐ Text or ☐ Phone Call

Emergency Contact ______________________ Phone __________

Relationship to Patient ______________________________

Referring Physician ______________________ Phone __________

Diagnosis ______________________________

Date of Injury / Onset / Surgery: ______________________________

Was This Related to an Accident? Auto/ Work / Other Date of Accident __________

Have you had prior Physical Therapy, Occupational Therapy, Chiropractic, or Acupuncture visits this year? Yes / No If yes, how many visits? ______________

Are you currently, or have you received Home Health Services this year? Home Health services can be, but are not limited to nurse, physical therapy, occupational therapy, wound care, IV or other medication administration. Yes / No

If yes, have you been discharged? Yes / No Date of Discharge ______________

* Please note that if you have Medicare and are currently receiving Home Health services, you may not begin outpatient physical therapy without first being discharged from Home Health.

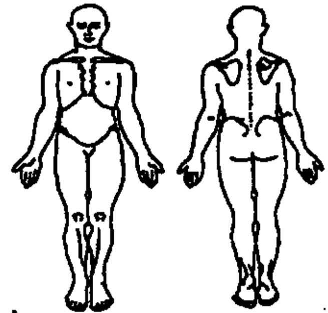
MEDICAL HISTORY

PATIENT NAME: ____________________ AGE: ________

*HEIGHT: ________ *WEIGHT: ________ ONSET DATE OF INJURY: ________

CONDITION/TYPE OF INJURY OR CAUSE: ____________________
(Is this due to an auto accident?)

TYPE OF SURGERY & DATE ____________________



PLEASE MARK AREA(S) OF CONCERN

HAVE YOU HAD ANY IMAGING PERFORMED:

- ☐ X-Ray
- ☐ MRI
- ☐ CT SCAN
- ☐ Ultrasound

Date of Imaging: ________

HAVE YOU RECENTLY NOTED:

- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Pregnant/IUD
- ☐ Pain at Night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Leg Cramps when Walking
- ☐ Fatigue
- ☐ Numbness/Tingling
- ☐ Change in Vision/ Hearing
- ☐ Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Surgeries
- ☐ Sprains/ Strains
- ☐ Heart Problems
- ☐ Circulation/ Clots
- ☐ Fainting
- ☐ Difficulty Swallowing
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma/ Breathing Problems
- ☐ Easy Brusing/Bleeding
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Arthritis
- ☐ Lung Disease
- ☐ Leg/Ankle Swelling
- ☐ Urinary Problems/Infections

EXPLAIN AND GIVE APPROXIMATE DATES FOR ANY ITEMS INDICATED ABOVE: ____________________

____

*TYPE OF ALLERGIES (IF ANY) : ____________________

* LIST OF CURRENT MEDICATIONS	*DOSE	*FREQUENCY
________	________	________
________	________	________

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

*Are you taking VITAMIN D? ☐ YES ☐ NO

*Describe the pain in the last 24 hours: DURING ACTIVITY ________ (SCALE OF 1-10) DURING REST ________ (SCALE OF 1-10)

What makes the pain better or worse? ____________________

*Have you had 2 or more FALLS within the last 12 months? ☐ YES ☐ NO

*Have you had at least one FALL WITH AN INJURY in the last 12 months? ☐ YES ☐ NO

What are your goals for Physical Therapy? (PLEASE USE BACK OF FORM)

X____________________ ________
PATIENT OR AUTHORIZED SIGNATURE DATE

PATIENT NAME:____

______ ***Consent for Care and Treatment***

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

______ ***Authorization for Signature on File and release of Information***

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be as valid as an original.

______ ***Authorization for Assignment of Benefits***

I, the undersigned, hereby assign all medical benefits, to which I am entitled to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay directly to the above named practice.

______ ***Financial Responsibility***

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

______ ***Notice of Privacy Practices***

I have read and fully understand the named practice's Notice of Practices. I understand that the above named practice 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 used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that the above named practice 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 the above named practice'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 have read and fully understand all of the above information and hereby agree to comply as outlined above.

____

Patient or Guardian Signature **Date**

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Important Notice for Medicare Patients

Outpatient physical therapy is not a covered service by Medicare if you are concurrently receiving home health services.

Home health services may include, but are not limited to

- Physical therapy
- Occupational therapy
- Speech therapy
- Nurse services
- Wound care, bandage changes
- Administration of medication or immunization shots
- Intravenous therapy

If you are unsure whether the services you are receiving at home qualify as home health care, please contact your Medicare plan and your home health agency.

____ No, I am not currently receiving home health services

____ Yes, I am currently receiving or have received home health services in the last year. Start date________________ End Date________________

If yes, please note that we require a copy of your signed home health discharge before you can begin outpatient physical therapy services.

By signing this document I, ____________________________, agree to notify Evergreen Physical Therapy Specialists, Inc. if/when I begin any home health services throughout the duration of my outpatient physical therapy treatment. I understand that once I start home health services, I cannot receive outpatient physical therapy services.

______________________________ ____________

Signature of Patient date

Evergreen Physical Therapy Specialists, Inc.
Coronavirus Disease 2019
Non-Personnel Questionnaire

If you have been fully vaccinated for two or more weeks, please indicate below your name at the bottom of this form.

All non-personnel (patients, visitors, vendors, etc.) will be asked to complete this form or to verbally attest to the questions posed on each in-person visit. A daily log will be maintained to record verbal attestations.

Please check the **Yes** or **No** boxes; do not check both the yes and no boxes.

1. Have tested positive for COVID-19 in the past 10 days? Yes ☐ No ☐
2. Are you currently awaiting results from a COVID-19 test? Yes ☐ No ☐
3. Have you been diagnosed with COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
4. Have you been told that you are suspected to have COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
5. Have you had any of these symptoms in the past 48 hours?

Symptom	Yes	No
Fever over 100.4° or chills	☐	☐
Persistent cough	☐	☐
Shortness of breath/difficulty in breathing	☐	☐
Fatigue	☐	☐
New loss of taste or smell	☐	☐
Sore throat	☐	☐
Muscle or body aches	☐	☐
Congestion or runny nose	☐	☐
Nausea or vomiting	☐	☐
Diarrhea	☐	☐
Headaches	☐	☐

In order to comply with OSHA's Emergency Temporary Standard for exempt outpatient providers we are prohibited from allowing COVID-19 positive or suspected positive individuals from entering our facility past our screening point. We will make every attempt to provide patient treatments via telehealth, in these situations if permitted by law. Should this not be available we will provide a list of potential facilities that may be available for continued treatment during this restriction period.

Name: ______________________________ Date: ________

Vaccinated: Yes ☐ No ☐

This Information is Highly Confidential & Will be Securely Managed

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