MAXIM PHYSICAL THERAPY

PATIENT PERSONAL INFORMATION

Name: ____
Last Name First Name Middle Name

Street Address/ P.O. Box ______________ City ________ State _____ Zip _____

Home Phone: (____) ______________ Cell Phone: (____) ______________

Date of Birth: ___/___/___ Age: ______ Sex: ______ Marital Status: _________ Social Security#: _____-_____-_____

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

Employer Address: ______________ City: __________ State: _____ Zip: __________

Referring Physician: ______________ Injury: ______________ Date of Injury: __________

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

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

Relationship to Patient: ______________ Social Security #: _______-_______-_______

Responsible Party's Home Phone: (____) ______________ Work Phone: (____) ______________

Address: ______________ City: __________ State: ________ Zip: ________

Employer's Name: ______________ Address: ______________________

INSURANCE INFORMATION

PRIMARY Insurance Company's Name: ______________________ ID#: __________

Name of Insured: ______________ Date of Birth: ___/___/___ Relationship to Insured: __________

Insurance Address: ______________ City: __________ State: ________ Zip: ________

Employment of Insured: ______________________ Work Phone: (____) __________

SECONDARY Insurance Company's Name: ______________________ ID#: __________

Name of Insured: ______________ Date of Birth: ___/___/___ Relationship to Insured: __________

Insurance Address: ______________ City: __________ State: ________ Zip: ________

Employment of Insured: ______________________ Work Phone: (____) __________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________

Address: ______________ City: __________ State: ________ Zip: ________

Phone #: (______) ______________ Work: (_____) ______________

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, I hereby authorize **Maxim Rehab Inc** to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to said minor.

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

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

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?:

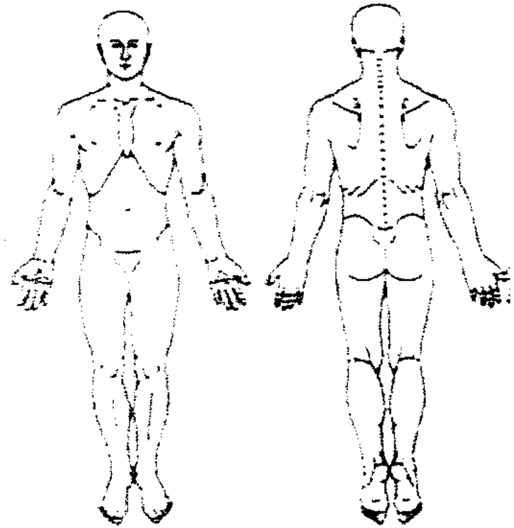
- ☐ Sitting
- ☐ Lying down
- ☐ Walking
- ☐ Standing
- ☐ Heat/Ice
- ☐ Medication
- ☐ Other - Massage, Acupuncture, etc..

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.

Current condition only!
Please mark where you hurt.



Patient (your) goals:

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

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 **