

CAHILL PHYSICAL THERAPY

Patient Information

Please Select Location Preference: Brentwood Beverly Hills

Patient Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: Home: _____ Work: _____ Cell: _____

Social Security No.: _____ Sex: Male Female Date of Birth: ____/____/____

Employer: _____ Occupation: _____

E-mail: _____ (receive appointment confirmations and reminders)

Spouse or Parent/Guardian:

Name: _____ Relationship to Patient: _____

Address: _____

Employer: _____ Business Phone: _____

In case of emergency, whom may we contact? _____ Ph: _____

DATE OF INJURY/ONSET OF PAIN: ____/____/____ SURGERY: ____/____/____

Area(s) of pain and area(s) to be treated: _____

Have you had any physical therapy visits this year? _____ How many? _____

INSURANCE INFORMATION: Primary Insurance: (Disregard if we already verified your insurance)

Name of Policy Holder: _____ Relationship to Patient: _____

Name of Insurance: _____ Policy/Group No: _____

Insurance Phone for verification of benefits: _____ Contact: _____

INSURANCE INFORMATION: Secondary Insurance: (Disregard if we already verified your insurance)

Name of Insurance: _____ Policy Holder's Name: _____

SS#: _____ Phone No: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Comments: _____

Patient Signature: _____ Date: ____/____/20____

CAHILL PHYSICAL THERAPY
Patient Medical History Questionnaire

PRESENT ILLNESS OR INJURY:

For what condition or symptoms are you being seen at this time? _____

When did this condition begin? _____

What treatment have you already received? _____

Has this problem occurred in the past? _____

PAST MEDICAL HISTORY

Please check if you have had any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Kidney or Bladder Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tumor or cancer |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Pneumonia or Emphysema |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hepatitis: Type _____ | <input type="checkbox"/> Are you now pregnant? |
| <input type="checkbox"/> Do you have a pacemaker? | <input type="checkbox"/> Do you have surgical implants? |

SURGERY:

Please list all previous operations and indicate the approximate date or age at the time of the procedure
(e.g.: *Left Hip Replacement: 3/1998, L4/L5 fusion: 11/2004*)

FRACTURES OR OTHER SERIOUS INJURIES: (Please list type and date)

MEDICATION: (Please list all present medications, include dosage and how often you take it.)

COMMENTS: _____

CAHILL PHYSICAL THERAPY

INSURANCE BENEFIT VERIFICATION

I have reviewed my insurance benefits and understand my responsibilities for co-payments, deductibles, and number of treatments allowed per my insurance company. I have asked questions about my insurance plan as needed and fully understand my responsibility for the overall treatment.

I further understand that when services are no longer of medical necessity or insurance benefits have been exhausted, I will be discharged on my own recognizance with the appropriate home care plan. You may continue physical therapy treatments in our clinic for the out-of-pocket rate. Please inquire as to this rate if interested.

By signing below, I agree to adhere to the benefits in my insurance plan and to the plan of care set forth by the physical therapist involved in my care.

Full Name (please print): _____

Signature: _____ **Date:** _____

24 HOUR CANCELLATION POLICY

Failure to cancel appointments within 24 hours of the scheduled appointment time will result in a **\$35 cash fee to be assessed.**

By signing my name below, I agree to adhere to the above mentioned 24 cancellation policy and understand that I will be charged for not cancelling within 24 hours.

Signature: _____ **Date:** _____

HIPAA ACKNOWLEDGEMENT

The Federal Health Information Portability and Accountability Act (HIPAA) requires us to be very careful with patient information.

Please read the summary of the HIPAA Privacy Rule at:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>

Sign below after you have reviewed the privacy summary in the link above:

Signature: _____ **Date:** _____

CAHILL PHYSICAL THERAPY, INC
Catherine M. Cahill, DPT

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Identification Number/Social Security: _____

Primary Insurance: _____

Secondary Insurance: _____

I hereby authorize Catherine M Cahill, DPT of Cahill Physical Therapy and Cahill Physical Therapy, Inc. to furnish to my insurance carrier(s) any and all requested information concerning my health care.

I also authorize my insurance carrier(s) to pay Catherine M. Cahill, DPT (Cahill Physical Therapy, Inc.) directly for services rendered.

Signed: _____
(Patient or Legal Guardian)

Date: _____