Patricia Sitton Physical Therapy

Physical Therapy • Structural Integration • Pilates

321 3rd Street, #F • Laguna Beach, CA 92651 • 415.601.1145

Patient Information Sheet

First Name	Last Name	
Name of Party Responsible for Payment (if different)		
Address		
City	State	Zip
Home Phone	Cell Phone	Work Phone
E-mail		Date of Birth
Emergency Contact		Emergency Contact Phone Number
Referring Physician		Referring Physician Phone Number
Primary Care Physician		Primary Care Physician Phone Number

I have completed this information sheet and agree that the information that I have provided is accurate.

Signature _____Date _____

Signature of guardian _____ Date _____
(if under 18 years of age)

***I understand that I will be charged $50 cancel my appointment without 24- hours notice and the ENTIRE appointment fee if I NO SHOW**
_____ (initials)

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Medical History

Name _____ Date _____

Please check "yes" or "no" to the following health problems:

Yes	No		Yes	No		Yes	No	
___	___	Cancer	___	___	Pulmonary/Breathing	___	___	HIV/AIDS
___	___	Diabetes	___	___	Liver disorder/disease	___	___	Tuberculosis
___	___	Heart disease	___	___	Kidney/bladder disease	___	___	Arthritis
___	___	Chest pain	___	___	Thyroid disorder	___	___	Rheumatism
___	___	High blood pressure	___	___	Intestinal disorder	___	___	Dizziness
___	___	Arrythmia or pacemaker	___	___	Seizure	___	___	Fainting
___	___	High cholesterol	___	___	Open sore/wound	___	___	Smoking
___	___	Anemia/blood condition	___	___	Hepatitis	___	___	Severe night pain
___	___	Unexplained weight loss	___	___	Recent/current illness	___	___	Unexplained weakness
___	___	Allergies to latex						
___	___	Steroid or blood thinner use						
___	___	Bladder or bowel control problems						
___	___	Other _____						
___	___	Are you pregnant or is there any chance that you may be pregnant?						

Please, explain why you are currently in need of physical therapy/what is your primary complaint:

_____

Please, list any surgeries that you have had (with date):

_____

Please, list any recent hospitalizations with (with date):

_____

Current or recent medications: _____

Recent films (x-ray, MRI, CT scan) or other tests:

_____

I have completed this questionnaire and have had any questions regarding its content answered fully. I understand that if information has been left out for confidentiality reasons, I may be putting my and my therapist's safety at risk. I understand that if I choose not to disclose information in writing I may verbally communicate conditions to my therapist.

Signature _____ Date _____

Signature of guardian (if patient is under 18) _____

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Medically Informed Consent for Treatment

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services with Patricia Sitton, MPT. I understand that it is the therapist's sincere intent to educate me on every process, from completing these intake forms to what I may expect at the time of my discharge from physical therapy. Therefore, if "hands on" manual therapy techniques and/or exercises that are being used to restore normal function are not fully understood or desired it is my responsibility to obtain a clearer understanding or what the therapist's objectives are or immediately refuse this aspect of treatment. If I feel pain and/or do not consent or feel comfortable physically or emotionally with any aspect of the treatment, it is also my responsibility to make this immediately clear to the therapist providing treatment.

***Payment at the time of service.*

******Please read...Cancellation Policy**: Because I often have a waiting list, 24-hour notification is required for all cancellations so that attempts can be made to fill your vacated spot on my schedule. Patients with cancellations of less than 24-hour notification will be charged $50. No Show appointments without prior notification will be charged the full amount of your visit.*

This consent shall be on-going for the treatment period.

I have read this form and fully understand and accept its terms and conditions:

Patient's name _____

Patient's signature _____ Date _____

Signature of guardian (if patient is under 18 years of age) _____

Signature of witness _____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will **not** use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
-For purposes of public health and safety;
-To Government agencies for purposes of their audits, investigations & other oversight activities;
-To Government authorities to prevent child abuse or domestic violence;
-To the FDA to report product defects or incidents;
-To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
-When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

-To have access to and/or a copy of your health information;
-To receive an accounting of certain disclosures we have made of your health information;
-To request restrictions as to how your health information is used or disclosed;
-To request that we communicate with you in confidence;
-To request that we amend your health information;
-To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.

Acknowledgement of Receipt of Notice from Patricia Sitton Physical Therapy:
I hereby acknowledge that I have reviewed the Summary of this medical practice's Notice of Privacy Practices and am aware that I may view a more detailed Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate Relationship:
__ parent or guardian of minor patient
__ guardian or conservator of an incompetent patient
__ beneficiary or personal representative of deceased patient