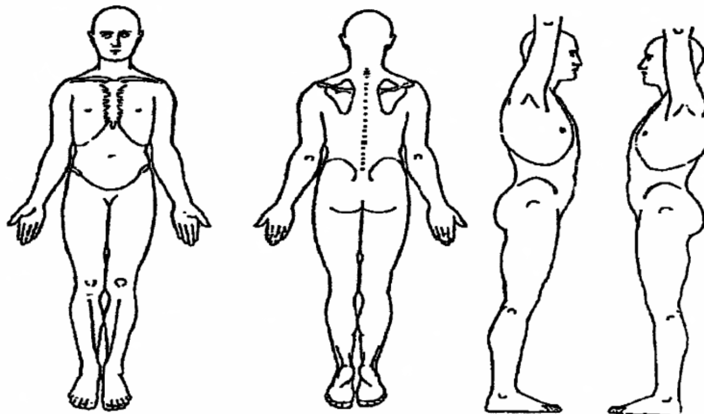
PATIENT INFORMATION

Name____ M or F (circle)
Address__________________________________ City_____________________ St_____ Zip_________
Home Phone(____)_______________ Wk. Phone(____)_____________ Cell (____)_______________
Please circle the phone number(s) you would prefer our office used to contact you or leave voicemail regarding appointments or medical information.
Birth date____/____/____ Age_____ Marital Status: M S W D Other (circle one)
Occupation____
Referring Physician____
Emergency Contact Name: _____________________________________ Relation:__________________
Day Phone(____)_____________ Evening Phone(____)_____________ Cell (____) _______________
Who may we thank for referring us to you? ____
Email Address (for appointment reminders /confirmations): ____________________________________
Do you prefer your appointment reminders to be emailed, texted or both? (circle one)

Body Diagram Directions: On the body diagram below, please mark the areas of your symptoms as they are at this moment.



MEDICAL HISTORY
Please indicate (X) any of the following whose care you are currently under:

____Medical Doctor ____Psychiatrist/Psychologist
____Osteopathic Physician ____Physical Therapist
____Dentist ____Chiropractor Other___________________

Medical History

Please indicate (X) whether you have ever been diagnosed with:

Osteoporosis________ Heart Disease/Heart Attack _____ Tumor or Cancer (Type)____
Respiratory Disease _____ Anemia or Blood Disorders ____ Asthma ____
Bleeding Disorders ______ Thyroid problems______ Hernia ____
Epilepsy/ Seizures ______ Circulation problems Stroke/TIA ____ Diabetes ____
Depression ____ Chemical Dependency ____ Autoimmune Disorders _____
Fibromyalgia/myofascial pain syndrome ______ High Blood Pressure Kidney or Bladder Problems ____
Other condition: ____
If you have checked any of the conditions, please explain____
____
Have any of your immediate family members been treated for any of the above conditions? If so, then please state what conditions and your relation.____

Are you pregnant now? Yes No
Have you had any illnesses in the last three weeks (e.g. colds, influenza, other infections)? YES NO
Describe:____
Please list all previous surgical procedures or hospitalizations, with approximate dates and reasons.
____
____
Do you have any surgical implants (plastic, metal…)? Yes No Explain_________________________
Please list all medications you are currently taking:____
____
Please list all allergies:____
Please list all imaging, with approximate dates (X-Ray, MRI, CT scan, Bone scan, PET scan, Ultrasound, EMG/Nerve conduction tests, etc.)
Date Image/Body Region
_____ ____
_____ ____
_____ ____
How many packs of cigarettes do you smoke per day?_______ Do you drink alcohol?___
How many days per week?___ How much do you drink per average sitting?______
Do you exercise regularly? YES NO What type of exercise and how often?_______________

CONSENT TO TREAT

My signature below is my consent to receive and pay for physical therapy treatment at Melia Perrizo Physical Therapy.

Patient Signature:____ Date:______________________
Parent/ Guardian Signature(if minor): ____________________________Date:______________________

MELIA PERRIZO PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully:

Understanding your health record/information:
When receiving physical therapy services from Melia Perrizo Physical Therapy, a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for educating physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated.

Our pledge regarding medical information:
We understand the medical information about you is personal. We are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.
2. **For payment**: We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.
3. **Review for quality care**: we may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.
4. **As required by Law:** We will disclose medical information about you when required to do so by federal, state or local law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested

I have read and understand the information outlined above.

___________________________	___________________________	_______________________
Print Name	Signature	Date
___________________________	___________________________	_______________________
Responsible Party if Not Patient	Signature	Date

Melia Perrizo
PHYSICAL THERAPY
women's health | orthopedics | pilates | holistic care

CANCELLATION/ NO SHOW POLICY

In order to maintain the high level of quality care and one- on-one service provided at Melia Perrizo Physical Therapy we ask that our patients comply with a 24-hour cancellation policy. We require a 24-hour advance notification when canceling an appointment. If the patient fails to comply with this 24-hour cancellation policy the fee of the missed session of $75 will be charged to the patient's account due the following scheduled visit. Melia Perrizo reserves the right to bill the patient for any uncollected cancellation fees. _______________ Initial & Date

OVER DUE BALANCES AND FEES

I understand I will be responsible for payment of overdue balances, which will be subject to a $35.00 late payment fee on balances 30 days over-due. I am also responsible to pay a $25.00 fee applied to any returned checks. All additional fees are payable directly to Melia Perrizo Physical Therapy.

_______________ Initial & Date

By signing this form I agree to the terms of the CANCELLATION POLICY and OVER DUE BALANCES AND FEES POLICY as stated above.

____________________________ ____________________________ ________________________
Print Name Signature Date

____________________________ ____________________________ ________________________
Responsible Party if Not Patient Signature Date