DSC
Physical Therapy, Inc.
and Sportsmedicine

Patient History

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

DATE OF BIRTH _____

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Person Responsible for Payments _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Driver's License Number _____

Person to Contact in Case of Emergency _____

Relationship _____ Phone Number _____

Your Employer _____

Address _____

City _____ State _____ Zip _____

Date of Injury _____ Patient Signature _____

Patient's Social Security Number _____ - _____ - _____ Patient's Occupation _____

Was injury accident related? ☐ Yes ☐ No ☐ Auto

Primary Insurance Carrier _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____

Name of Insured _____

Release of Information

I authorize DSC Physical Therapy, Inc. to release any information acquired in the course of my examination and/or treatment to my legal representative and/or insurance representatives and/or referring physician.

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for DSC Physical Therapy, Inc. to furnish medical care and physical therapy treatment considered necessary and proper by my referring physician.

Signature of Patient/Guardian/Responsible Party _____

Print Name _____ Date _____

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Name (Last, First Middle) _____ Date _____ Birthdate _____

Address _____

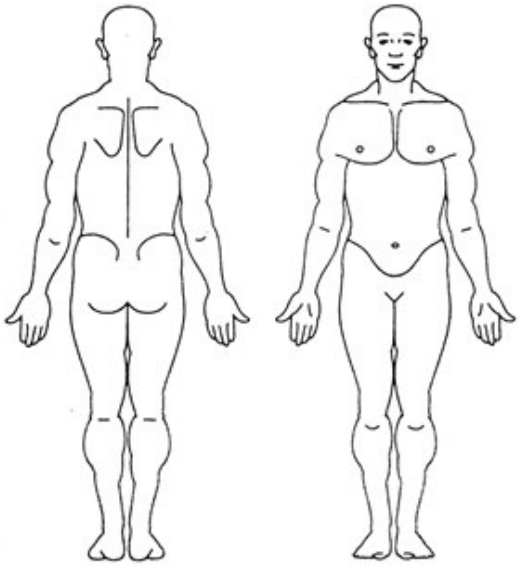
Briefly describe your problem and ink in the area of pain in the figure.

_____

_____

_____

_____



Please list any medications (pills) you currently take.

_____

_____

_____

☐ Yes ☐ No Do you frequently have severe headaches?
If yes, answer the following:
- ☐ Yes ☐ No Do they occur on one side of the head?
- ☐ Yes ☐ No Do they hurt most in the back of the head and neck?

☐ Yes ☐ No Do you have spells of dizziness?
☐ Yes ☐ No Do you have spells of weakness of an arm or leg?
☐ Yes ☐ No Do you have ringing in your ears?
☐ Yes ☐ No Have you ever had a convulsion?
☐ Yes ☐ No Have you ever had double vision?
☐ Yes ☐ No Do you ever have pain in your ear(s)?

Have you ever had chest pain
or tightness in the chest, which:
☐ Yes ☐ No Begins when exerting yourself?
☐ Yes ☐ No Begins when you are upset or excited?
☐ Yes ☐ No Radiates down the arm?
☐ Yes ☐ No Disappears when you rest?
☐ Yes ☐ No Occurs only at rest?
☐ Yes ☐ No Have palpitations?

☐ Yes ☐ No Have you ever been hospitalized? If yes, when and for what?

_____

_____

☐ Yes ☐ No Have you had any serious illness in the last 5 years? If yes, please describe:

_____

_____

☐ Yes ☐ No Have you ever had a serious accident? If yes, please explain:

_____

_____

Patient Signature _____

Please go to the next page

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FINANCIAL AGREEMENT

PAYMENT:

DSC Physical Therapy, Inc., (DSC) would obviously prefer full payment for services rendered at the end of each week. However, DSC will bill my insurance company as a courtesy. I understand that my co-payment is due on the last treatment day of each week. I understand that I am responsible for all charges incurred in the course of treatment and that I will be billed for all services that are not covered or are unpaid by my insurance company. If I am unable to pay the full amount due, I may follow this fee schedule:

Amount Outstanding	Minimum Amount Due
$1 -$99	Balance in Full
$100 -$299	$100 per month
$300 -$499	$150 per month
$500 or more	$200 per month

All outstanding balances that remain unpaid for 45 days or more after my last treatment date will be subject to 1½% interest per month.

RETURNED CHECKS:

A $10.00 charge will be added to my balance for each check returned for non-payment.

ASSIGNMENT OF BENEFITS:

I, _____, hereby authorize payment of medical benefits for services rendered to DSC Physical Therapy, Inc.

I authorize DSC to release information to my insurance company as necessary to obtain payment.

Date: _____ Signature: _____

Witness: _____

I understand that I will be charged $25.00 for any treatment appointment that is not cancelled at least four (4) hours in advance.

Signature: _____

410 Arden Ave., Suite 102
Glendale, CA 91203
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Fax (818) 240-8179

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La Cañada, CA 91011
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Fax (818) 790-9732