MIZUTA & ASSOCIATES PHYSICAL THERAPY

NEW PATIENT FORM

(Please Print)

Today's date:	Referring Doctor:
	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:					
City:		State:	ZIP Code		
Social Security #:	Email:		Home/Cell Phone: ( )		
Occupation:	Employer:		Work Phone: ( )		
How did you find out about Mizuta & Associates Physical Therapy?					
❑ Doctor Referral	❑ Family	❑ Friend	❑ Internet	❑ Other	

Consent for Care and Treatment

I, the undersigned, hereby and give my consent for Mizuta & Associates Physical Therapy to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her physical condition.

Benefit Assignment / Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare private insurance, and third party payers to Mizuta & Associates Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mizuta & Associates Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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MEDICAL HISTORY FORM

(Please Print)

Patient's Name: _____

Is this an injury or accident case? ❑ Yes ❑ No If yes, is there an attorney involved? ❑ Yes ❑ No

Are you currently taking any prescription or non-prescription medications? ❑ Yes ❑ No

If yes, list your medications: _____

Asthma, Bronchitis, or Emphysema	❑ Yes	❑ No	Severe or Frequent Headache	❑ Yes	❑ No
Coronary Heart Disease of Angina	❑ Yes	❑ No	Vision or Hearing Difficulties	❑ Yes	❑ No
Shortness of Breath/Chest Pain	❑ Yes	❑ No	Numbness or Tingling	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Dizziness of Fainting	❑ Yes	❑ No
Heart Attack or Heart Surgery	❑ Yes	❑ No	Bowel or Bladder Problems	❑ Yes	❑ No
Stroke/TIA	❑ Yes	❑ No	Weakness	❑ Yes	❑ No
Congestive Heart Failure	❑ Yes	❑ No	Hernia	❑ Yes	❑ No
Blood Clot/Emboli	❑ Yes	❑ No	Weight Loss/Energy Loss	❑ Yes	❑ No
Epilepsy/Seizures	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No	Allergies	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Pins or Metal Implants	❑ Yes	❑ No
Infectious Diseases	❑ Yes	❑ No	Joint Replacement Surgery	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Neck Injury/Surgery	❑ Yes	❑ No
Cancer or Chemo/Radiation	❑ Yes	❑ No	Shoulder Injury/Surgery	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Elbow/Hand Injury/Surgery	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No	Knee Injury/Surgery	❑ Yes	❑ No
Sleeping Problems	❑ Yes	❑ No	Back Injury/Surgery	❑ Yes	❑ No
Gout	❑ Yes	❑ No	Ankle/Foot Injury/Surgery	❑ Yes	❑ No
Emotional/Psychological Problems	❑ Yes	❑ No	Are you pregnant?	❑ Yes	❑ No
Do you have a pacemaker?	❑ Yes	❑ No	Do you use tobacco?	❑ Yes	❑ No

List any other information that you feel would assist us in your care: _____

_____

_____

_____

_____ _____

Patient/Guardian signature *Date*

MIZUTA & ASSOCIATES PHYSICAL THERAPY

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

The following are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any questions about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding and compliance of the above privacy practices.

_____ _____

Printed Name Date

_____

Signature