YONEMOTO
PHYSICAL THERAPY SERVICES, INC.
55 S. Raymond Ave. • Suite 100 • Alhambra • CA 91801 • (626) 576-0591 • Fax (626) 576-5890 • http://www.yonemoto.com

For Office Use Only
P.T.: _____ Acct.#: _____
Eval Date: _____ Time: _____

Date: _____

Patient Information:

Name: _____ Sex (circle): M / F Birth date: _____ Age: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Driver's License Number: _____
Cell Phone: _____ E-mail address: _____
Social Security/Medicare Number: _____ Marital Status: _____

Employer:

Name of Company: _____ Phone: _____
Address: _____ City: _____ State: ____ Zip: _____
Your Occupation: _____

Spouse/Parent Information:

Spouse/Parent Name: _____ Spouse/Parent Work Phone Number: _____
Spouse/Parent Employer: _____

Nearest Relative (not living with you) – In Case of *Emergency*:

Name: _____ Relationship: _____ Phone Number: _____
Address: _____ City: _____ State: ____ Zip: _____

Referring Doctor:

Name: _____ Phone Number: _____
Address: _____ City: _____ State: ____ Zip: _____
Family Physician Name: _____ Dr's Phone Number: _____
Problem you are having: _____
Diagnosis: _____ ICD9 DX Code: _____

Are you involved in litigation at this time? (Circle one) Yes / No
Is this injury accident related? (Circle one) Yes / No
If yes, please briefly describe the accident for insurance purposes: _____
_____

I, _____,
CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND COMPLETE.
Signed: _____ Date: _____

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PLEASE READ AND SIGN

Dear Patient:

Yonemoto Physical Therapy Services, Inc. will bill your insurance company as a courtesy.

Please be advised that this is a brief summary. The benefits outlined are given as quoted by an Insurance representative. THIS IS NOT A GUARANTEE OF PAYMENT BY THE INSURANCE COMPANY.

Yonemoto Physical Therapy Services, Inc. will carry your account for 60 days. If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered at Yonemoto Physical Therapy Services, Inc. Accounts remaining open after sixty (60) days are subject to a 1.5% per month late charge. Unpaid accounts will be turned over to collections.

Yonemoto Physical Therapy Services, Inc, reserves the right to charge the patient a cancellation fee of $45.00 if the cancellation is not made within twenty-four (24) hours of the scheduled appointment. (Note: Cancellation fees are not covered by insurance plans.)

This agreement is binding regardless of any legal transactions currently in progress or initiated during the course of physical therapy treatments, unless agreed upon in writing by Yonemoto Physical Therapy Services, Inc.

FOR OFFICE USE ONLY - Please do not fill out items in this box.

Primary Insurance	*Secondary Insurance*
Insurance Co._____	Insurance Co._____
Insured _____	Insured _____
Deductible _____ Met___	Deductible _____ Met_____
Benefits _____	Benefits _____
Limitations_____	Limitations_____
_____	_____
_____	_____

I, _____, have read and do fully understand the above information provided for me and hereby agree to comply as outlined.

_____ _____

Signature Date Signed

(01/11)

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FINANCIAL WAIVER FORM

Dear Medicare Patient:

Yonemoto Physical Therapy is a participating Medicare Provider and we will bill your Part B benefits for the 80% covered by Medicare. The remaining 20% balance due is the patient's responsibility or a second insurance company maybe billed for the amount.

Also, Medicare has a calendar year deductible and the patient is responsible for that amount if it is not covered by your supplemental insurance. Please check with the Finance Department for more information about the coordination of benefits with your insurance company.

If you are currently receiving Home Health Services, please advise our office. Medicare will not cover Part B Physical Therapy benefits concurrently with a Home Health Agency.

I have read the above statements and understand my financial responsibilities. I waive my rights to insurance benefits if I have not accurately informed Yonemoto Physical Therapy of my insurance coverage prior to treatment.

_____ _____

Patient Signature Date

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Acknowledgment of Receipt of Notice of Privacy Practices

Yonemoto Physical Therapy Service reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Yonemoto Physical Therapy Service.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

PATIENT QUESTIONNAIRE

Name: _____
Referring Physician: _____
Date:

Pain Rating

Use this chart as a reference for the question below.

0	1	2	3	4	5	6	7	8	9	10
No Pain			Moderate		Strong		Very Strong		Emergency	

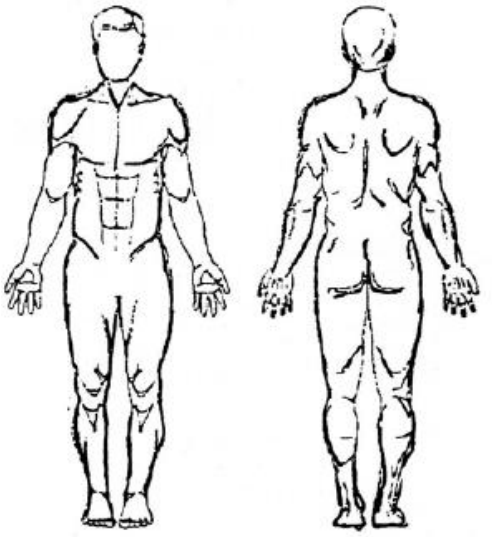
Choose the number from the rating chart above that best describes the severity of your pain:
On Average: _____ At its best: _____ At its worst: _____
What percentage of the day do you have pain or discomfort? 0% 10% 15% 25% 50% 75% 90% 100%
Is your pain the worst in the… Morning: _____ Evening: _____ Both: _____ Evening:_____

Explain: _____

_____

Describe or illustrate your symptoms on the diagram using these symbols:

/// Stabbing XXX Burning OOO Pins & Needles = = = Numbness > > > Shooting



Other descriptions of your symptoms: _____

_____

_____

_____

_____

_____

Social History

Age: _____ Number of children: _____

	YES	NO
Do you exercise regularly?	____	____
What type of exercise? _____		
Do you take vitamins/ minerals?	____	____
Do you drink alcohol?	____	____
How much? _____		
Do you drink coffee/tea/colas?	____	____
How much? _____		
Do you smoke cigarettes or cigars?	____	____
How much? _____		

Work History

Do you work or did you work at the time of your injury / illness?	____	____

If yes, please answer the following:
What is / was your job title? _____
Which work tasks affect your pain? _____

Are you currently on disability? _____ _____

Other Symptoms YES NO

Do you have difficulty staying asleep due to your pain? _____ _____
Do you have weakness in your arms or legs? _____ _____
Do you have weakness in your neck or back? _____ _____
Do you have problems with dizziness? _____ _____
Do you have problems with blurred vision? _____ _____

Do you have problems with swelling? _____ _____
Do you have problems with joints popping or cracking? _____ _____
Do you have to lie down or recline during the day due to your pain? _____ _____
Does stress affect your pain? _____ _____

Do you have problems with nausea or vomiting? _____ _____
Do you have abdominal pain? _____ _____
Do you have difficulties with bowel or bladder control? _____ _____

Please describe the activities that cause you the most trouble:
_____

Have you fallen within the past year? _____ _____

If so, how many times? _____

Did any of the falls result in any kind of injury? _____ _____
If so, please explain:
_____

Medical History

Are you receiving therapy due to an injury? _____ _____
If so, what was the date of the injury or accident? _____

_____

Please describe what happened at the time of the injury _____
If this problem is not injury-related, how long have you had your current symptoms? _____
Have you had previous physical or occupational therapy for your present condition? (circle one) Yes / No
List any diagnostic testing you have had (X-ray, MRI, CT scan, etc.): _____
_____

Do you have a history of the following?

	Yes	No	If Yes, give date:		Yes	No	If Yes, give date:
Diabetes	____	____	_____	Allergies to Heat/Ice	____	____	_____
High Blood Pressure	____	____	_____	Other Allergies	____	____	_____
Heart Disease	____	____	_____	Previous Surgery	____	____	_____
Heart Attack	____	____	_____	Hernia	____	____	_____
Pacemaker	____	____	_____	Seizures	____	____	_____
Headaches	____	____	_____	Dental Implants	____	____	_____
Kidney Problems	____	____	_____	Tuberculosis	____	____	_____
Nervous Disorders	____	____	_____	Hepatitis	____	____	_____
AIDS	____	____	_____	Cancer	____	____	_____
Pregnancies	____	____	_____		____	____	_____

Please explain what medications you are currently taking and for what condition(s):

Medication	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____

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Patient Health Questionnaire

Patient Name: _____ Date: ____/____/____

E-mail Address: _____ Phone Number: (___) ___-____

A large percentage of our patients have been asking us about natural ways to address their health issues. In response to their questions and expressed need, we have done extensive research to find the most advanced health and wellness program. Please take a moment to give us your thoughts with regard to this new program.

1. Are you currently taking any type of nutritional supplement (including any supplement for weight loss on a regular basis)?
   ☐ Yes ☐ No

2. If you answered **Yes**, check the supplements you currently take:
   ☐ Multivitamin ☐ B-Complex ☐ Coenzyme Q-10
   ☐ Omega III ☐ Glucosamine ☐ Probiotics
   ☐ Antioxidant ☐ Vitamin C ☐ Weight Loss
   ☐ Calcium ☐ Digestive Enzyme
   ☐ Other, please list: _____

3. Who recommended these products to you?
   ☐ Family member ☐ Health Professional ☐ Vitamin store
   ☐ Friend ☐ Pharmacy ☐ Advertisement
   ☐ Health Provider ☐ Website ☐ Mail Order
   ☐ Other, please list: _____

4. Would you be interested in getting more information on an effective, medically supervised, weight management program based on increased fat loss without stimulants?
   ☐ Yes ☐ No

5. Would you like to take advantage of a free consultation with our Wellness coach to discuss a health and wellness program customized to your individual health needs?
   ☐ Yes ☐ No

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Dear New Patient,

Welcome to Yonemoto Physical Therapy!

The Yonemoto Physical Therapy team is here to help you improve movement and function, relieve pain, and expand your movement potential. Through evaluation and individualized treatment programs, physical therapists can treat existing problems and provide preventive health care for people with a variety of needs.

Treatment may include mobilizing stiff joints and tissue, exercise stretching, and education. The goals of physical therapy are to restore or achieve optimal movement/function and to relieve pain.

You should notice changes in how your body is functioning or feeling during or after therapy. It is always good to tell your therapist anything you're noticing so they can modify your treatments appropriately, if needed.

Proper attire for therapy would be comfortable clothing, such as shorts, sweats, T-shirts and tennis shoes. We kindly request that you not bring small children into the gm are for safety reasons. The gym equipment is for patient use only.

Our office hours are: M-F 8:00am - 5:30pm

If for any reason you cannot make a scheduled appointment, please call our office at (626) 576-0591. Our answering machine is on after hours and 24 hours on Saturday and Sunday. We do charge a fee of $45.00 for not showing up for an appointment without giving our office at least 24 hours notice. This charge is to cover our therapists downtime, if we are unable to schedule someone else in that slot. (PLEASE NOTE: You are responsible for this $45.00 payment before or at your next visit. It is not covered by your insurance.)

Insurance deductibles and any co-payment due will be collected at each visit. Our financial representatives will meet with you and answer any questions you may have. You have several payment options: cash, check, Mastercard or Visa.

While receiving therapy at Yonemoto Physical Therapy, we want to know that we are servicing you the best we can. For that reason we have placed a "Suggestion Box" in the reception area and gym. Please use it if there is anything we can improve in our service.

If you have any questions, please do not hesitate to ask. Again, welcome to Yonemoto Physical Therapy!

Sincerely,
Sheila Yonemoto, PT