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

Yonemoto Physical Therapy Services, Inc.

Medical Insurance HIPAA Notice

HIPAA Notice of Privacy Practices for Personal Health Information

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.

Dear Patient:

This is your Health Information Privacy Notice from Yonemoto Physical Therapy Service. **Please read it carefully.** You have received this notice because of your physical therapy services with our office. This notice refers to Yonemoto Physical Therapy Service by using the terms "us", "we", or "our".

This notice describes how we protect the personal health information we have about your which relates to your physical therapy treatments, and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your present or future health, treatment, or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For Additional information regarding your HIPAA Medical Information Privacy Policy or our general privacy practice please contact a representative in our office. You may submit questions to us or you may write to us directly at Yonemoto Physical Therapy Services, Inc. 55 S Raymond Avenue, Suite 100, Alhambra, CA 91801.

We are required by law to:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information;
- Follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service you are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services. The main reasons for which we may **use** and may **disclose** your Personal Health Information are to evaluate and process any requests for services that may be of interest to you.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Health Insurance Coverage and treatments.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right hand corner of the notice.

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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

Yonemoto Physical Therapy Services

Patient: _____

Consent Form for Physical Therapy

Informed Consent to Treatment I hereby consent, by my own free will, to voluntarily engage in an in-person visit by a licensed physical therapist. The physical therapist will explain the purposes of the evaluation and provide a treatment plan that may include therapeutic exercises, therapeutic activities. soft tissue/hands on physical therapy and modalities. These recommendations will be made by my therapist to improve my condition and overall wellness.

My therapist will make every effort to address my symptoms, functional deficits (if any), and concerns for relief of symptoms and/ or improvement of function. I recognize that these sessions will allow me to learn ways to move better, feel better, and teach me techniques and skills that I can utilize independently on a daily basis. I am aware that addressing my symptoms or diagnosis may take a few sessions and I am required to closely follow all provided instruction to ensure improvements. The number of sessions will vary based on the primary complaints and symptoms.

I may not get immediate relief of symptoms and may even have an aggravation of symptoms. I will honestly report my symptoms to my physical therapist so that he/she can best guide my treatment. I can decline any suggested treatment and also stop any treatment at any time.

I consent that I have read, agree with, and understand the above statements and consent to physical therapy.

Signature: _____ Date: _____

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	

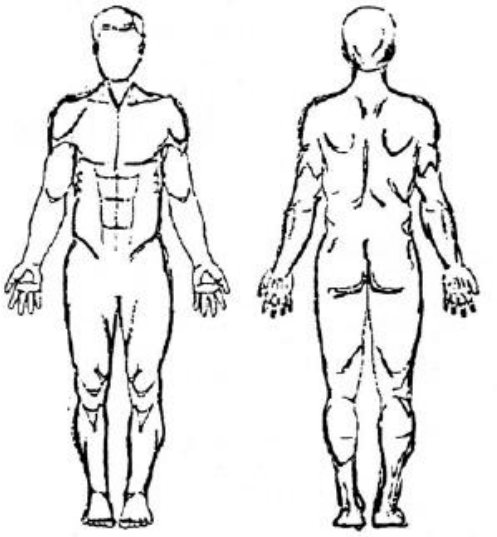
Choose the number from the rating chart above that best describes the severity of your pain:
On Average: _____ At its best: _____ At its worst: _____
What percentage of the day do you have pain or discomfort? 0% 10% 15% 25% 50% 75% 90% 100%
Is your pain the worst in the… Morning: _____ Evening: _____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