

# Welcome to Fountain Valley Physical Medicine

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone # (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Adjuster's Phone number: \_\_\_\_\_

Do you have an attorney?  Yes  No Attorney's name and phone number: \_\_\_\_\_

## Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking (including anti-inflammatory medication) : \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
|  | <input type="checkbox"/> Other _____     |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please explain under comment and notify the Doctor:

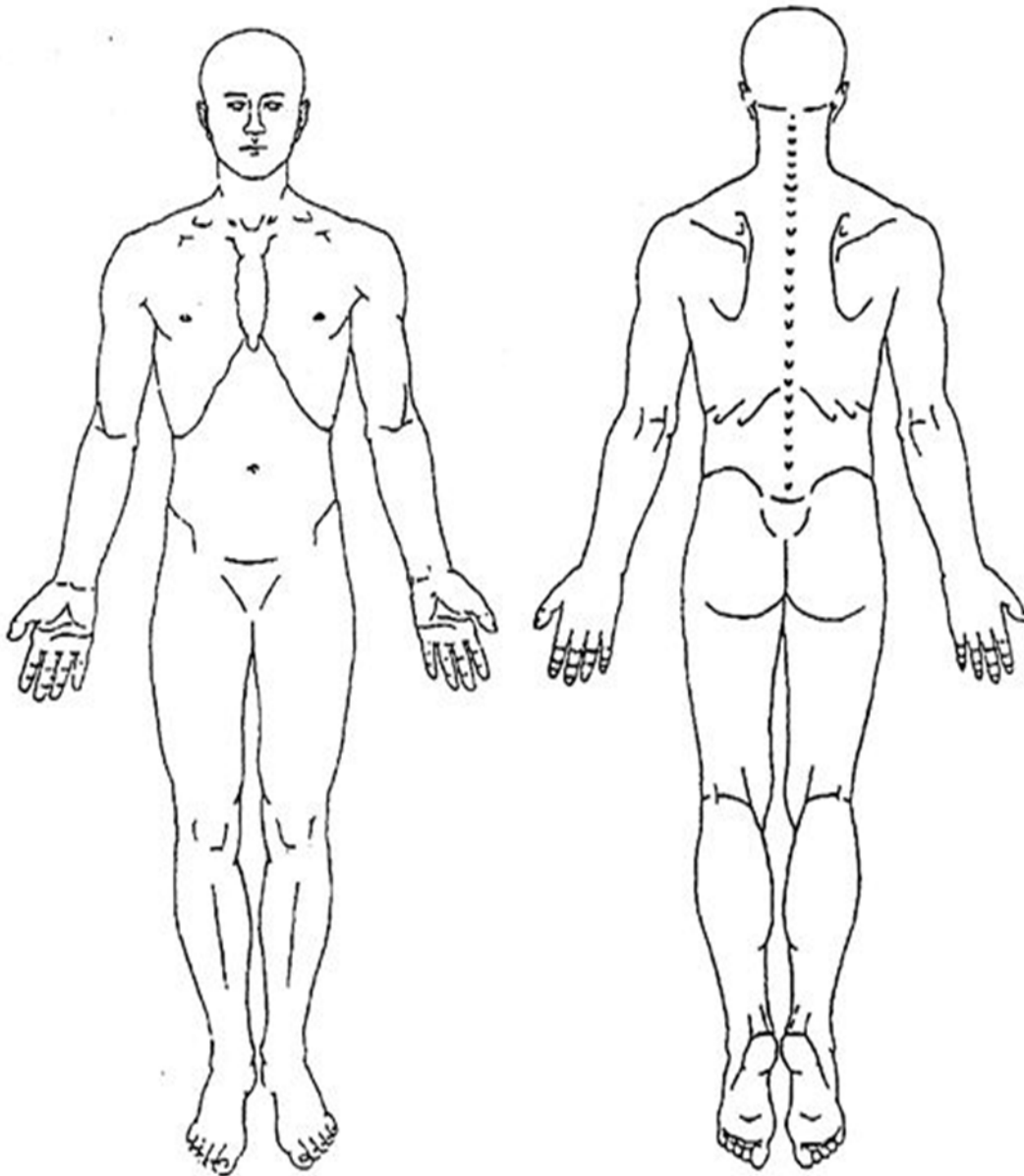
- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____  | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____   | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____   | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____   | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____  | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____   | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____  | NO | YES |
| 8. Do your legs or feet fall asleep regularly?<br>Comment: _____  | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____  | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____  | NO | YES |
| 11. Have you tried any Physical Therapy or Chiropractic treatments before?<br>If yes: When? For how long? What kind? _____<br>_____       | NO | YES |
| 12. Have you had an MRI?<br>If yes: When? Who ordered it? What was it ordered for? _____<br>_____   | NO | YES |
| 13. Have you used any splint or braces or other prescribed treatment by an MD?<br>If yes: When? What kind? Who ordered it? _____<br>_____ | NO | YES |

<p><b>NOTE: Your health information will be kept strictly confidential.</b> Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare</p>
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# Body Map

Name: \_\_\_\_\_ Date \_\_\_\_\_

On the diagram below, please circle the areas where you experience any pain or discomfort.



# CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: \_\_\_\_\_

\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Non-Assignment of Insurance Benefits Policy**

I have been informed that my insurance company will not assign benefits over to this office. This means that any amount due to the doctor’s office would be mailed to me, the patient, and not to this office.

Since my insurance company will not assign benefits directly to the office, I am opting to follow the below ‘Non- Assignment of Benefits’ policy.

Our office will treat you and you will be responsible to pay your deductible, co-payments or co-insurance that is due for each of your allowed visits by the insurance company. To do this, our office will need a credit card on file. As the insurance disburses funds to you, the patient, you are required to bring the payments to this office within seven (7) days. As you receive payments, or an Explanation of Benefits (EOB), our office also receives a copy of what you received, minus any payments.

If we have not received the payment from you, the patient, within seven (7) days, our office will charge that amount that you received from the insurance company on the credit card on file.

NOTE: We will only charge the credit card if payment is not brought in within seven (7) days.

If unusual circumstances should arise where you can’t bring the payment in, please call the office to let us know so the credit card won’t be charged. (Ex. You’re out of town, emergency, etc.)

If the insurance company denies your claim, you will be responsible for services rendered.

I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

\_\_\_\_\_  
Patient’s Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient’s Signature

**FOUNTAIN VALLEY PHYSICAL MEDICINE**

**Instructions:**

1. Have the “Insured” person of the policy sign the back of the check
2. Bring the check and EOB (explanation of benefits) to our office within 7 days. **DO NOT DETACH THE CHECK FROM THE EOB.**
3. Give the EOB/Check to the front desk when you arrive to our office. We will make a copy for your records.

Fountain Valley  
Physical Medicine  
18042 Magnolia St  
Fountain Valley, CA 92708  
P: (714)962-1674 F: (714)964-9624

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I acknowledge that I have reviewed the Notice of Privacy Practices of Fountain Valley Physical Medicine. (Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I wish to receive an electronic copy of Privacy Notice.

My email address is: \_\_\_\_\_

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

\_\_\_\_\_ I acknowledge that it is the policy of FVIPM to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

## Financial Office Policies for Fountain Valley Physical Medicine

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks, cash, and Care Credit.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

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Patient Signature or Responsible Party

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/ /  
Date



