Dr. Deanna Mekata, P.T., D.P.T. **HealthSummit Physical Therapy**

260 S. Sunnyvale Ave.
Suite 2
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(408) 329-9604

WE ARE PLEASED TO WELCOME YOU TO OUR OFFICE

Date:_____

Patient Information

First Name:_____ Int.____ Last Name:_____ DOB:__/_____/_____
Home Address:_____City:_____ State:____ Zip:_____
Home#: ( )_____Work#: ( )_____Cell#: ( )_____E-mail: _____
Sex: (M) (F) SS#:_____-_____-_____ Drivers License#:_____
Occupation: _____ Patient Employer:_____
Employer Address: _____City:_____ State:_____ Zip: _____
In case of an emergency, who should be notified?_____ Phone#: ( )_____
Relationship:_____ Address:_____
If patient is a minor, name of responsible guardian:_____
How were you referred to our office?_____

Primary Insurance Information

Insured first name:_____ Int.____ Last Name:_____ DOB:_____/___/_____
Insured address:_____
Patient relationship to insured (circle): Self Spouse Child Parent Insured SS#:_____-_____-_____
Sex (M) (F) Employer Name:_____ Employer Phone#: ( )_____
Insurance Company & Address:_____
Group#:_____ Policy#:_____ Insurance Co. Phone#: ( )_____

Financial Policy

As a courtesy, we do call your insurance company prior to your appointment. Any estimated insurance co-pays, and deductible amount is **due at time services are rendered in order to control cost of billing.** I understand that due to insurance policy changes and/or necessary changes in treatment plans, the insurance may vary from the estimated treatment calculation. I acknowledge that this is an estimate only and that I am ultimately financially responsible for all services rendered, not the insurance company. I also understand that all services are due to be paid in full within (90) days of date of service, whether or not my insurance benefits have been received. Should my account exceed (90) days, an interest rate of %1.5 per month will be charged to my account.

Missed Appointments

We recognize the value of your time, and except in the case of an emergency, you can expect us to serve you. If for some reason you should **miss, reschedule, or cancel** your appointment without notifying our office **24 hours prior** to your appointment, you will be charged for the full rate of your visit.

Authorization

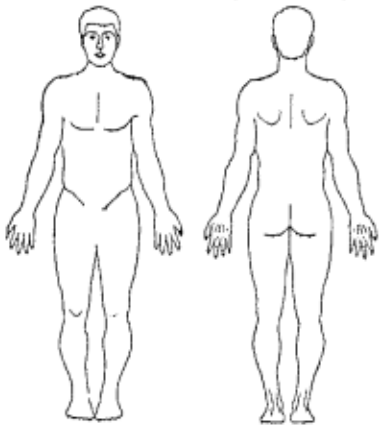
I,_____, authorized Dr. Deanna Mekata to examine and provide me with appropriate treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Dr. Deanna Mekata authorize Dr Deanna Mekata to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial reimbursement. I understand it is my responsibility to know all rules and restrictions of my insurance policy. It is Dr. Deanna Mekata procedure to share Protected Health Information with consulting physicians. We will only exchange minimum necessary Protected Health Information for each transaction.

My signature below is my acknowledgment and consent to the above and the back of this form and certifies that I have filled out this health questionnaire completely and have advised you of all medical problems of which I am aware.

Signature of **Patient** (or **Guardian** if patient is a minor) X_____ Date:_____

HealthSummit Physical Therapy

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries/Medications: _____

_____

_____

_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my **Physical Therapist** or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my **Physical Therapist** and/or ASH Plans to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____