Moscardi Physical Therapy

911 Oak Park Boulevard, Suite 105
Pismo Beach, California 93449
Phone 805-481-8272 : Fax 805-481-8045

WELCOME… to Moscardi Physical Therapy. Our Physical Therapists are trained professionals who treat all orthopedic and neurological conditions related to the extremities and the spine. We develop individual programs which are sports specific or related directly to the work environment so that the patient can return to his or her previous lifestyle.

Your physician has referred you to physical therapy with a given diagnosis. Based upon this referral, our therapists will perform an evaluation, develop a treatment plan and treat your injury or disease. We continually reassess your status and will progress your treatment accordingly. Our goal is to start in our medical facility, instructing you in exercises specific to your injury. Then, if appropriate, you will be transitioned into a gym setting to be able to continue your exercise program on a higher level.

LOCATIONS:
Pismo Medical Campus
911 Oak Park Boulevard Suite 105
Pismo Beach, CA 93449
(805) 481-8272 phone
(805) 481-8045 fax

Our hours are from 7:00am - 5:00pm Monday through Friday

TREATMENTS… are by appointment only. Please telephone our office at **(805) 481-8272** to schedule an appointment.

APPOINTMENT CANCELLATION POLICY… We at Moscardi Physical Therapy, Inc. take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every patient. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and your personal treatment is delayed. For these reasons, we have the following office policy:

> Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask that you provide at least 24 hours notice to avoid a $25.00 cancellation/no show fee. If commitments for appointments are frequently broken, a non-refundable reservation fee equal to the appointment fee may be required. We do have an answering machine for your convenience during non-working hours, weekends, and holidays.

IN CONCLUSION… Our primary goal is to provide you with the highest quality physical therapy possible. Please help us assist you in your recovery by keeping all of your physical therapy appointments.

Thank you for choosing Moscardi Physical Therapy!

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Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

MOSCARDI PHYSICAL THERAPY, INC. is required by law to protect the privacy of your personal health information. We provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

MOSCARDI PHYSICAL THERAPY, INC. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For Example, **MOSCARDI PHYSICAL THERAPY, INC.** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

MOSCARDI PHYSICAL THERAPY, INC. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research study purposes and for emergencies. We also provide information when required by law.

In any other situation, **MOSCARDI PHYSICAL THERAPY INC.** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENTS INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **MOSCARDI PHYSICAL THERAPY INC.** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **MOSCARDI PHYSICAL THERAPY, INC.** may have violated your rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact us at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact us.

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Patient Information and Admission Form

Patient Name: _____ Circle: M / F
(last, first, middle, preferred)

Address: _____
(street, city, state, zip)

Email Address: _____ paperless billing? (circle one) yes / no

Home Phone: _____ Cell Phone: _____

Preferred Method of Communication (circle one) : Home Phone / Cell Phone / Email / Other: _____

SSN: _____ Date of Birth: _____ Age: _____

Employer: _____ Phone Number: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Name of Insured: _____

Patient Relationship to Insured: _____ Insured Date of Birth: _____

Primary Insurance: _____ Phone Number: _____

Address: _____

Member ID No. _____ Group No. _____

Secondary Insurance: _____ Phone Number: _____

Address: _____

Member ID No. _____ Group No. _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us? (circle one) Doctor website friend patient other: _____

Reason for Physical Therapy? _____

Date of Injury / Surgery: _____ from a Motor Vehicle Accident? yes / no

Have you had any **out-patient** Physical Therapy for current problem? (circle one) yes / no

Any Physical Therapy or Chiropractic Therapy **this calendar year**? (circle one) yes / no

Have you received any of the following tests for your current issue? (mark all that apply)

☐ X-rays ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ EMG ☐ Nerve Conduction Study ☐ Other: _____

Do you currently have or had in the past any of the following?

Balance Issues / Any Falls?	yes	no	Seasonal or Medical Allergies	yes	no
Heart Disease / Attack	yes	no	Current Smoker	yes	no
Diabetes Type I or Type II	yes	no	Pacemaker	yes	no
High Blood Pressure	yes	no	Headaches	yes	no
Cancer	yes	no	Metal Implants	yes	no
Nervous Disorder	yes	no	Sensitivity to Heat or Ice	yes	no
Kidney Problems	yes	no	Breathing Difficulties	yes	no
Seizures	yes	no	Vision Problems	yes	no
Hernia	yes	no	Hearing Problems	yes	no

Please explain any above **yes** including approximate dates: _____

Please list any **medications** you are currently taking: _____

List any past **surgeries**: _____

What is your **height**?_____ Current **weight**?_____ Are you, or is there a chance that you could be pregnant?_____

Please mark on the scale below your **pre-injury** / **pre-surgery** level of function (circle one)

1% --------- 10% -------- 20% -------- 30% -------- 40% -------- 50% -------- 60% -------- 70% -------- 80% -------- 90% -------- 100%

Please mark on the scale below your **current** level of function (circle one)

1% --------- 10% -------- 20% -------- 30% -------- 40% -------- 50% -------- 60% -------- 70% -------- 80% -------- 90% -------- 100%

On a scale of **0** to **10** (0 being no pain at all) what level would your rate your pain? _____

Which best **describes** your pain: ☐Sharp ☐Throbbing ☐Aching ☐Tingling ☐Burning ☐Numb ☐Shooting ☐Other_____

Which activities **increase** your symptoms? (mark all that apply)

☐ Sitting ☐ Walking ☐ Driving ☐ Kneeling ☐ Twisting ☐ Standing ☐ Reaching ☐ Stairs ☐ Lifting ☐ Bending
☐ Squatting ☐ Rising ☐ Lying Down ☐ Other: _____

What **eases** your symptoms? (mark all that apply)

☐ Moist Heat ☐ Ice Pack ☐ Medication ☐ Rest ☐ Change in Position ☐ Other: _____

Describe the physical requirements of your job: _____

What benefits do you expect to gain from physical therapy? (please be specific)

a) _____

b) _____

The above information is correct to the best of my knowledge.

I confirm that this course of treatment is **not** due to a work related injury or connected to a workman's compensation claim.

I hereby authorize Moscardi Physical Therapy to provide treatment, and to furnish my insurance company and physician, full information regarding treatment rendered, when so requested.

I hereby authorize my insurance company to pay directly to Moscardi Physical Therapy medical benefits otherwise payable to me, and I will be responsible to Moscardi Physical Therapy for all expenses incidental to treatment rendered not paid under my plan.

_____ _____

Patient / Guardian Signature Date

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Consent Form

Therapy is a patient care service provided in response to a wide range of medical care needs for patients of all ages regardless of gender, color, race, creed, national origin, or disability.

The purpose of therapy is to treat disease, injury, and disability by evaluation, examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Moscardi Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for.

There are certain inherent risks with physical therapy treatments. You will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. Moscardi Physical Therapy reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. Furthermore, I understand that the physical therapist may terminate my treatment at any time. I have read and received a copy of the consent form and authorize release of medical information to appropriate third parties.

Patient Name: _____ Date: _____

Patient / Guardian Signature: _____