NICOLE GODETT
Physical Therapy

Medical History Questionnaire

Name:_____Age:_____Height:____Weight:_____Occupation:_____
Emergency Contact: _____Phone Number:_____Relationship:_____
Reason for Therapy: _____Date of Onset: _____
Is the Reason for Therapy Accident Related? ❑ Yes ❑ No
If **yes**, please check one: ❑ Accident ❑ Auto ❑ Work ❑ Fall ❑ Strenuous Lifting ❑ Other:_____
Treatment received so far for this condition (chiropractor, injection, etc):_____
Please list tests performed for this problem (x-ray, MRI, labs, etc):_____
Have you received any therapy during this calendar year for this condition? ❑ Yes ❑ No If so, when_____
Have you ever had this problem before? ❑ Yes ❑ No How long did it take for you to feel better?_____
If so, how was the problem treated?_____
Could you be or are you currently pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
Do you/have you smoked? ❑ Yes ❑ No Do you have a pacemaker? ❑ Yes ❑ No Allergic to latex? ❑ Yes ❑ No

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain (circle one)	❑ heartburn/indigestion	❑ fainting
❑ pain at night	❑ difficulty swallowing	❑ cough
❑ falls/difficulty with balance	❑ changes in bowel or bladder function	❑ headaches
❑ changes in/painful menstruation	❑ infection	❑ swelling

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer/tumor:_____	❑ depression	❑ thyroid problems
❑ heart problems:_____	❑ lung problems:_____	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis/osteopenia
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy/seizures
❑ blood clots	❑ arthritis	❑ eye problem/infection
❑ stroke/TIA (circle one)	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection:_____	❑ sexually transmitted infection/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia
❑ hypersensitivity to heat/cold	❑ hernia	❑ head injury/concussion
❑ previous fractures	❑ anxiety	❑ painful/abnormal menstruation
❑ other: _____	❑ incontinence: _____	❑ painful intercourse

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer:_____	❑ aneurysm	❑ tuberculosis	❑diabetes
❑ heart problems:_____	❑ stroke	❑ thyroid problems	❑ ankylosing spondylitis
❑ high blood pressure	❑ depression	❑ blood clots	❑ other:_____

During the past month have you been feeling down, depressed or hopeless? ❑ Yes ❑ No
During the past month have you been bothered by having little interest or pleasure in doing things? ❑ Yes ❑ No
If **yes**, is this something with which you would like help? ❑ Yes ❑ Yes, but not today ❑ No
Please list any surgeries or other conditions for which you have been hospitalized, including dates: _____
_____
Please list any medication(s) you are allergic to:_____
Have you ever taken steroid medications for any medical conditions? ❑ Yes ❑ No
Have you ever taken blood thinning or anticoagulant mediations for any medical conditions? ❑ Yes ❑ No
Please list any medications you are taking and specify condition (or bring a list):_____
_____

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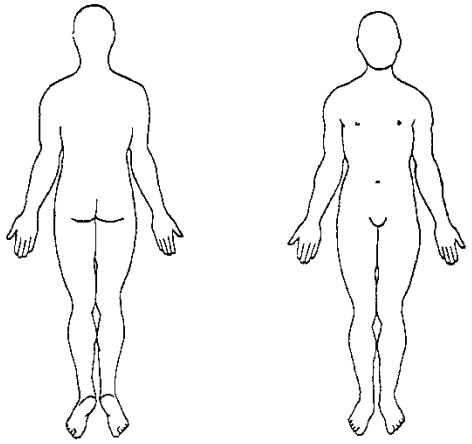
Current Symptoms

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey:_____
The ***best*** your pain has been during the past 24 hours: _____
The ***worst*** your pain has been during the past 24 hours: _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms ***worse***:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms ***better***:
1. _____
2. _____
3. _____

My pain/symptoms increase with walking or stair climbing and are relieved with rest? ❑ Yes ❑ No ❑ N/A
My symptoms currently**:** ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity
My symptoms are currently: ❑ Getting better ❑ About the same ❑ Getting worse
How are you able to sleep at night?
❑ No difficulty ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Only with medication
When are your symptoms the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
I should not do physical activities that might make my pain worse: ❑ Disagree ❑ Unsure ❑ Agree
Does coughing, sneezing or taking a deep breath make your pain feel worse? ❑ Yes ❑ No
Does bending, sitting, lifting, twisting or turning over in bed make your pain feel worse? ❑ Yes ❑ No
Has there been any change in your bowel habit since the start of your symptoms? ❑ Yes ❑ No
Does eating certain foods make your pain feel worse? ❑ Yes ❑ No
Has your weight changed since your symptoms began? ❑ Yes ❑ No

At the present time, would you say your health is: ❑ Excellent ❑ Very Good ❑ Fair ❑ Poor

The information is correct to the best of my knowledge. I consent to examination and treatment.
Please sign:_____ Date: _____
(Patient/Parent/Guardian) If parent or guardian, please write name: _____

Nicole Godett Physical Therapy
901 N. Heritage Dr. Suite 106 | Ridgecrest, CA 93555 | Phone: (760) 301-5411 | Fax: (760) 301-5408

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Financial Information

PAYMENT OPTIONS: *(Please **INITIAL** next to the payment option you're using)*

_____ **Private Pay – *Not using insurance*; I am paying by cash or credit card at the time of service.**

Initials You have been offered the opportunity to personally pay for your physical therapy evaluation and treatment at Nicole Godett Physical Therapy. The private pay policy is used in the following circumstances:

1. Patient has no insurance
2. Physical therapy is not covered by patient's insurance
3. Patient chooses to forego insurance benefits
4. Patient chooses to pay for services up front and to personally seek reimbursement from their insurance

The following conditions apply:

1. Once you have chosen the private pay terms, I will not bill your insurance carrier for services rendered.
2. **Payment is due at the time of service**. I accept cash or credit card
3. Up to 45 minute appointment: $145. Please ask about cost if you would like a longer appointment.

_____ **Health Insurance *-will take copies of insurance card(s) at first visit***

Initials Primary Insurance Company: _____

Policy Holder: _____ Date of Birth: ____ / ____ / _____ SS#: _____ - ___ - _____

Secondary Insurance Company: _____

Policy Holder: _____ Date of Birth: ____ / ____ / _____ SS#: _____ - ___ - _____

Payment Policy

I require a credit card on file to cover the cost of the appointment such as cash pay rate, deductible, co-pay and co-insurances. This will also be used to cover any late cancelations and no – shows fees as noted below. I use Ivy Pay, a HIPAA compliant credit card processing service. The Terms of Use for using Ivy Pay can be found here: https://www.talktoivy.com/ivy-pay-payor-terms-of-use.

Ivy Pay has a few benefits:

- I am able to charge you for sessions without swiping a card at each appointment
- The service is secure and compliant with HIPAA standards for client confidentiality
- Your credit card information is stored with Ivy Pay, not in my files or other records; I do not have access to your stored credit card information
- You would be able to review past charges and payments in a text message thread

The service works simply:

- You provide a phone number, which I enter into the provider's Ivy Pay app along with a charge for the session fee
- Ivy Pay texts you a secure link leading to a page where you enter your credit card information and approve the first charge
- After future sessions, I use Ivy Pay to charge the stored card; the app sends you a text informing you that I've done so

You will only be asked to enter your credit card information once (unless you need or wish to change the card), and you do not need to download an app or regularly interact with Ivy Pay.

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Cancellation Policy

Appointments: I realize that on rare occasions you may need to reschedule or cancel an appointment. I request that you contact my office **at least** 24 hours in advance of your appointment time to cancel so that the appointment made be made available to others on my waiting list. Please leave a message on my voicemail after hours, if necessary. You may also text.

There will be a $75 'no-show' fee if you do not arrive for your appointment and fail to cancel. This will be automatically charge to the credit card on file.

Cancellations made with less than 24 hours notice (for any reason) will be charged a $75 fee. This will be automatically charge to the credit card on file. IF I am able to fill your last minute cancellation this fee will be waved.

Initial: _____

Release of Information: I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at Nicole Godett Physical Therapy (NGPT) to release such records, upon request, to our facility. Furthermore, I authorize NGPT use or release of any of my records it may have to third-party payers, government agencies, healthcare providers, or any other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by NGPT.

Name of Referring Physician & Phone Number:_____
Name of Primary Care Physician & Phone Number: _____
If your Primary Care Physician is not your referring physician, would you like your evaluation, progress note(s) and discharge summary to be sent to them? □ Yes □ No

I have read the financial responsibilities, payment policy, cancellation policy and release of information sections and by signing below consent to these policies.

_____	_____	_____
Print Name	**Signature of Patient or Responsible Party**	**Date**
___Nicole Godett_____	_____	_____
Witness Printed Name	**Signature of Witness**	**Date**

NICOLE GODETT
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Statement of Financial Policy

(Applies to insurance billing only)

Welcome to **Nicole Godett Physical Therapy (NGPT).** I assure you that you will receive the very best care available for your condition. The following information will familiarize you with the insurance financial policy of this office and how your medical bills will be handled. A copy of this form is available upon request.

Explanation of Insurance Coverage/Insurance Billing: As a courtesy, I can file your insurance claims for you.

I suggest that you contact your insurance carrier prior to your first scheduled appointment to verify physical therapy coverage. Regardless of your insurance coverage, your policy is a contract between you and your insurance carrier. You are ultimately responsible for payment which may include a co pay, coinsurance, and/or deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account.

Payment Arrangements: Verification of your insurance benefits indicates you are responsible for:
Deductible: $_____ has/has not been met. $_____ payment at each visit.
Co-insurance is: _____ % payment each visit or Co-pay: $_____ payment each visit.

Your portion of the bill must be paid within 30 days of the billing date. Any unpaid balances will be considered past due and will be sent to collections after 75 days.

Authorization for Payment/Assignment of Benefits: I hereby instruct **Nicole Godett Physical Therapy** to bill my insurance company for services rendered and said insurance company to make direct payment of medical benefits to:

Nicole Godett Physical Therapy
901 N. Heritage Suite 106
Ridgecrest, CA 93555

I also understand that should my insurance company send payment to me, I will forward the payment to NGPT within 48 hours. I agree that if I fail to send the payment to the NGPT and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. I authorize NGPT to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I have read the above information and by signing below consent to the above financial policy.

_____	_____	_____
Print Name	**Signature of Patient or Responsible Party**	**Date**
___Nicole Godett_____	_____	_____
Witness Printed Name	**Signature of Witness**	**Date**

NICOLE GODETT
Physical Therapy

Communication Policy

You have the option to communicate with Dr. Nicole Godett, PT via text and/or email. Communicating over text and email is available regarding appointments and brief questions.

Please note that any communication sent over text and email is **NOT** secure.

Please allow 1 business day for me to respond.

Texts can be sent to: 760-301-5411

Emails can be sent to: NicoleGodettDPT@gmail.com

If you would like to communicate via text please write your number: _____

If you would like to communicate via email please write your address: _____

I consent to communication with Dr. Nicole Godett, PT via text and/or email. I understand that these forms of communication are **NOT** secure.

Please sign: _____ Date: _____

Please leave blank if you do not wish to communicate in this manner. Thank you.

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Summary of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you wish to request a detailed version of this Privacy Practice Notice, please speak with Nicole Godett or view it on our website at www.NicoleGodettDPT.com (Effective Date January 2024)

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated. If so, please speak with Nicole Godett. You may also complain to the U.S. Department of Health & Human Services Office for Civil Rights.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Contact Information: Nicole Godett, (760) 301-5411

I acknowledge receipt of this notice:_____ **Date:**_____

If you are signing as the patient's representative, print your name and relation:

_____ _____

Name Relation

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