



NEW CLIENT FORM

PLEASE PRINT CLEARLY

PERSONAL INFORMATION

Name: (First) _____ (Last) _____ (M.I.) _____

Home Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if different): _____

Sex: M / F Date of Birth: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____ Phone: _____

Would you prefer text message or email reminders for your upcoming visits?

Text Message: Cell # (if different as listed above): _____

Cell Phone Provider: AT&T / Verizon / Cingular / T-Mobile / Virgin Mobile / Other: _____

Email (please fill in email address above)

How did you hear about us?

- | | | | | |
|--|---------------------------------------|--|--|---|
| <input type="checkbox"/> TV | <input type="checkbox"/> Social Media | <input type="checkbox"/> Community Event | <input type="checkbox"/> Direct Access | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Website | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Friend/Family | <input type="checkbox"/> Referring MD |
| <input type="checkbox"/> Email | <input type="checkbox"/> Review Sites | <input type="checkbox"/> Athletic Training | <input type="checkbox"/> Employer | <input type="checkbox"/> Self-Referral |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Print Ad | <input type="checkbox"/> Gym | <input type="checkbox"/> Staff | <input type="checkbox"/> Returning Client |

Other: _____

Have you had physical therapy/speech therapy/chiropractic treatment this calendar year? Yes No

If Yes, Where? _____

Do you currently or have you in the past 6 months had Home Healthcare Services? Yes No

If Yes, Where? _____

AUTO ACCIDENT INFORMATION

Date of Accident: _____

Were you taken to the hospital? _____

If yes, were you transported via ambulance? _____

Was this accident work related? _____

Were you the driver of the vehicle? _____

Was a police report made? _____

State in which the accident occurred? _____

Have you received any physical therapy treatment at another facility in relation to your auto accident? _____

If yes, where and when? _____

Attorney Involved? Yes / No Attorney Name: _____ Phone: _____

Attorney Address: _____

INSURANCE INFORMATION

Auto Insurance Carrier: _____ Subscriber Name: _____

Policy #: _____ Claim #: _____

Adjustor Name: _____ Phone: _____ Med Pay Limit: _____

Primary Health Insurance: _____ Secondary Health Insurance: _____

COMPLETE this section only if you are **NOT** the subscriber:

Subscriber Name (Primary): _____ Subscriber Name (Secondary): _____

Date of Birth: _____ Date of Birth: _____

Relationship to Patient: _____ Relationship to Patient: _____

GUARANTOR INFORMATION

If patient is a **MINOR** please provide the following information as the guarantor of their account:

Guarantor Name: _____ Date of Birth: _____ Relationship: _____

Client/Guardian Signature: _____ Date: _____



OFFICE POLICY/ PRIVACY PRACTICE ACKNOWLEDGEMENT

FINANCIAL POLICY: Our practice accepts 1st party auto insurance plans only. (Clients have the option to bill their own automotive insurance company for services rendered.) We bill your insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred.

The attached benefits information is not all-inclusive. It is limited to coverage limitations, terms of your contract with your insurance, terms of any direct or indirect contract we hold with the payer, and your specific insurance plan's interpretation of the medical necessity of the services provided. Please refer to your insurance plan's applicable benefit agreements to determine any limitations or exclusions for your rehabilitation services.

The attached benefits have been quoted to us by your insurance carrier and have been reviewed with you. Benefits are subject to change. We assume no liability for any errors made by your insurance carrier. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Furthermore, I understand that I cannot change my chosen payment option after services have been rendered.

- I choose to pay the estimated amount quoted per visit. I have received a printout of my benefits. I understand that ultimately it is my responsibility to know the extent of my benefits. _____ (please initial)
- I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment. _____ (please initial)
- I choose to seek reimbursement from a third party auto insurance. For this reason I agree to pay a non-discounted charge and receive an itemized statement. _____ (please initial)
- I have a signed Attorney Lien on file. _____ (please initial)

CONSENT FOR CARE & TREATMENT: Your Clinician will complete an evaluation and/or follow up visits by examination and interview in clinic or by synchronous audio video technology (Telehealth). Your individual treatment program will then be designed and adjusted as needed and a variety of treatment techniques may be used. Regardless of visit type, the treatment medium will be HIPAA compliant, the patient and/or provider has the right to stop the treatment session for any reason at any time, and a formal grievance process is available to the patient to report any issues with their experience. I the undersigned do hereby agree and give my consent for **Central Valley Physical Therapy** to furnish care and treatment in an in-clinic or Telehealth medium considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR TREATMENT OF A MINOR: I authorize **Central Valley Physical Therapy** to treat _____
(Minor's name)

- Above named minor may attend visits unattended by parent/guardian after initial evaluation and may sign his/herself in at each appointment. Telehealth appointments cannot be completed independently by a minor, a parent/guardian must be present throughout the duration of each visits. _____ (client/guardian initial)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Central Valley Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$65 a visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

CO-PAYMENTS: Co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a \$25 processing fee.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT: By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* for the Movement for Life clinics. Our notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full notice. If you have any questions about our Notice of Privacy Practices that our registration staff cannot answer, please contact our Privacy Office at 805-788-0805 or 1106 Walnut Street, #110, San Luis Obispo, CA 93401.

CLIENT / GUARDIAN SIGNATURE

DATE

PLEASE PRINT NAME

(Relationship to client: self, guardian)

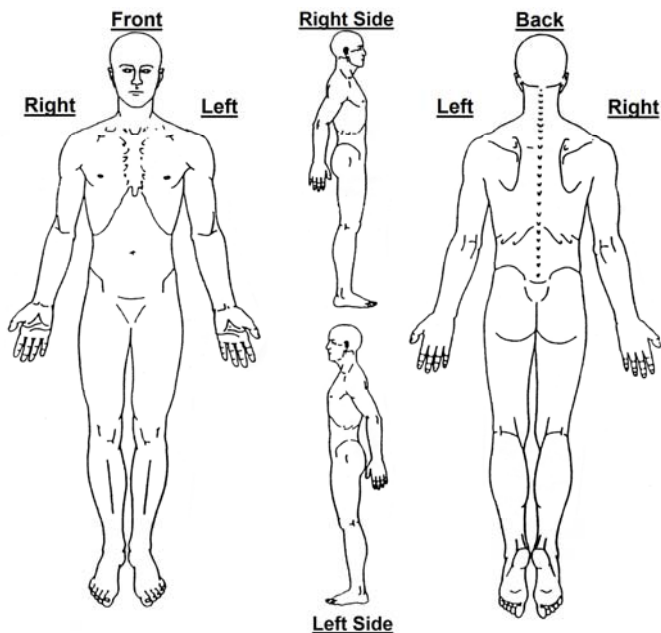


Medical Screening Form

Name: _____ Age: _____ Occupation: _____

CURRENT CONDITION:

Please use these symbols to note symptom location: ^^^ Numbness *** Pins & Needles /// Pain



When/How did these symptoms occur? Date _____

Gradually Suddenly Injury

Please describe: _____

My symptoms are currently:

Getting Better About the Same Getting Worse

Have you ever had this problem before?

YES NO

If so, how was the problem treated and did it help? _____

Have you had any imaging studies for this condition?

(x-rays, MRI, etc)? YES NO

What are your physical therapy goals?

Currently, I am experiencing the following (check all that apply):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Increased Pain at Night | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Fatigue > 2-4 weeks or Generalized weakness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Depression | <input type="checkbox"/> Changes in Appetite | |
| <input type="checkbox"/> Changes in Bowel / Bladder Function | <input type="checkbox"/> Fever / Chills / Sweats | <input type="checkbox"/> Numbness or Tingling | |

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Have you fallen over the past 12 months? Yes No If so, how many times? _____

PAST MEDICAL HISTORY:

Please check any condition that you currently have or have had in the past:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> History of blood clot | <input type="checkbox"/> Circulation/Bleeding Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Lung Disease/Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Cancer –Type _____, Treatment _____ | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Pacemaker | |
| | | <input type="checkbox"/> Angina | |

Are you allergic to latex? YES NO Are you pregnant? YES NO

Do you smoke? YES, amount/per day _____ NO Are you allergic to steroids? YES NO

Do you drink? YES, amount/per day _____ NO Do you use Marijuana/CBD? YES NO

Are you currently taking any medications? YES NO

If yes, please list ALL medications you are currently taking. Please include dose/frequency or provide a list: (If needed a full page Medication Log can be provided)

Please list any medical conditions AND past surgeries with dates that have not been documented above:



AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if required by Law or Rules

(1) Client's Printed Name:

Last First Initial or Other

Date of Birth: ____/____/____

(2) Central Valley Physical Therapy will only disclose the protected health information you want disclosed.

Check only one box to tell Central Valley Physical Therapy the specific information you want disclosed/released:

Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

Limited information (complete ALL Sections)

(3) Complete only if you selected "limited information". Please initial all that apply:

____ Evaluation/Examination ____ Attendance ____ Correspondence re: your Physical Therapy Services
____ Past Medical History ____ Treatments ____ Physical Therapy Bill / Statement
____ Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Self: _____ Other: _____

(5) Check only one box indicating how long Central Valley Physical Therapy can use this authorization:

Disclose my information indefinitely (as long as Central Valley Physical Therapy has custody of my files)

Disclose my PHI for the following period beginning ____/____/____ and ending ____/____/____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying Central Valley Physical Therapy in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Central Valley Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Central Valley Physical Therapy will not be compensated for using or disclosing my PHI, unless related to treatment/payment procedures, without specific permission from me after full disclosure of purpose and intent

Signature of Client Date OR Signature of Parent or Authorized Representative Date
(Indicate the Relationship)

You May Refuse to Sign this Authorization