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?

☐ *TV*	☐ *Social Media*	☐ *Community Event*	☐ *Direct Access*	☐ *Insurance*
☐ *Radio*	☐ *Website*	☐ *Yellow Pages*	☐ *Friend/Family*	☐ *Referring MD*
☐ *Email*	☐ *Review Sites*	☐ *Athletic Training*	☐ *Employer*	☐ *Self-Referred*
☐ *Internet Search*	☐ *Print Ad*	☐ *Gym*	☐ *Staff*	☐ *Returning Client*

☐ *Other:*__________

Have you had physical therapy/speech therapy/chiropractic treatment this calendar year? ☐ 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 by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Avid Physical Therapy** to furnish care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR TREATMENT OF A MINOR: I authorize **Avid 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. __________________ *(client/guardian initial)*

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Avid 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**

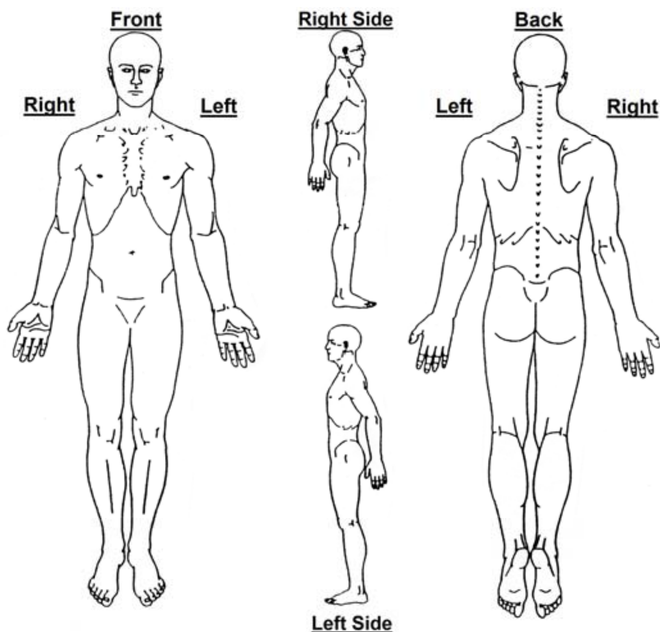
______________________________ ______________________
PLEASE PRINT NAME **(Relationship to client: self, guardian)**

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):

☐ Dizziness	☐ Increased Pain at Night	☐ Nausea / Vomiting	☐Fatigue > 2-4 weeks or Generalized weakness
☐ Headaches	☐ Unexplained Weight Loss/Gain	☐ Shortness of Breath	☐ Other________
☐ Difficulty Swallowing	☐ Depression	☐ Changes in Appetite	
☐ Changes in Bowel / Bladder Function	☐ Fever / Chills / Sweats	☐ 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:

☐ High Blood Pressure	☐ Kidney Disease	☐ History of blood clot	☐ Circulation/Bleeding Problems
☐ Stroke	☐ Heart Disease/Problems	☐ Arthritis	☐ Osteoporosis
☐ Lung Disease/Problems	☐ Liver Disease	☐ Asthma/Allergies	☐ Fibromyalgia
☐ Cancer –Type___________, Treatment_____________	☐ Diabetes ☐ Type 1 ☐ Type 2	☐ Pacemaker	
		☐ Angina	

Are you allergic to latex? ☐ YES ☐ NO

Do you smoke? ☐ YES, amount/per day________ ☐ NO

Do you drink? ☐ YES, amount/per day________ ☐ NO

Are you pregnant? ☐ YES ☐ NO

Are you allergic to steroids? ☐ YES ☐ 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:

____

____

Attention: Medical Records
1106 Walnut Street, #110
San Luis Obispo, CA 93401
Phone: (866) 387-7778
Email: recordsrequests@movementforlife.com

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) *Avid Physical Therapy* will only disclose the protected health information you want disclosed.
Check only one box to tell *Avid 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 *Avid Physical Therapy* can use this authorization:

☐ Disclose my information indefinitely (as long as *Avid 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 *Avid 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 *Avid 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
_______ *Avid 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

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

You May Refuse to Sign this Authorization