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*:_____

GUARANTOR INFORMATION

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

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

FINANCIAL POLICY: 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)

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)*

CANCELLATION & NO-SHOW POLICY: We require 24 hour 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.

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**

_____ _____

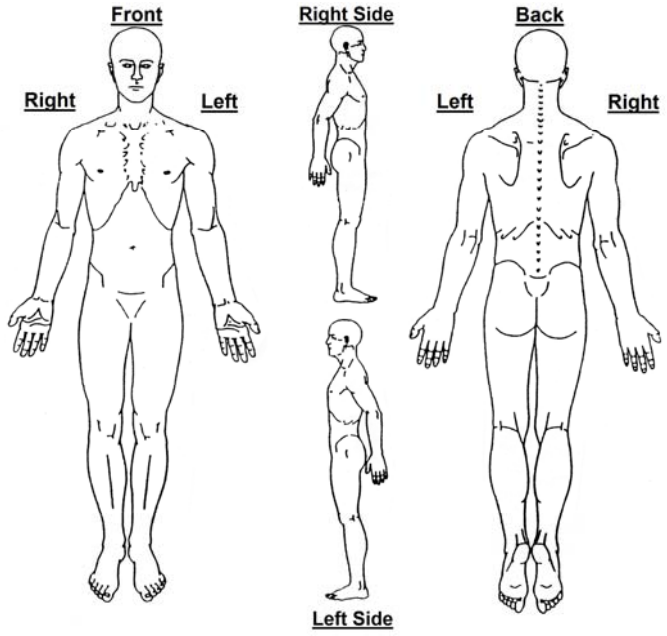
PLEASE PRINT NAME **(Relationship to patient: self, guardian)**

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 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:

_____

_____

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 (Indicate the Relationship)** **Date**

You May Refuse to Sign this Authorization