



# 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-Referred    |
| <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? \_\_\_\_\_

## INSURANCE INFORMATION

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 Client: \_\_\_\_\_

## 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:** We bill your personal 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)

**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)

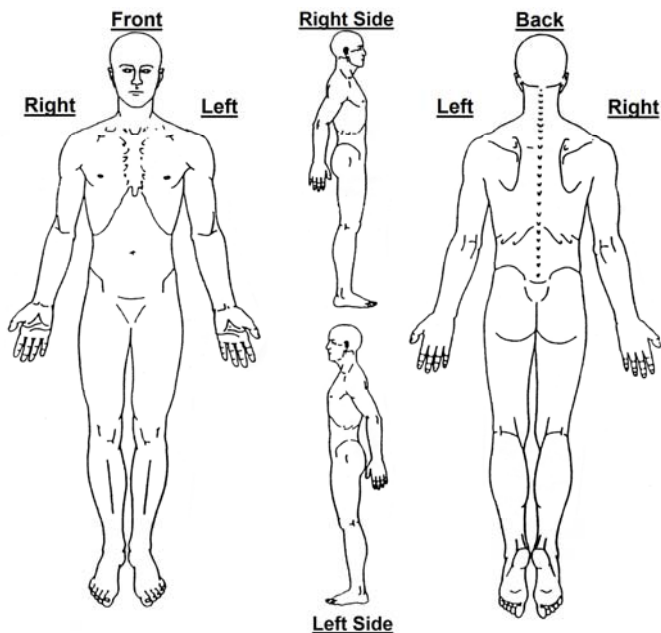


# Medical Screening Form

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):

- |  |   |   |  |
|--|---|---|--|
| <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<br><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:

