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?_____

Do you currently or have you in the past 6 months had Home Healthcare Services? ☐ 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 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 **Movement For Life 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 **Movement For Life 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 **Movement For Life 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**

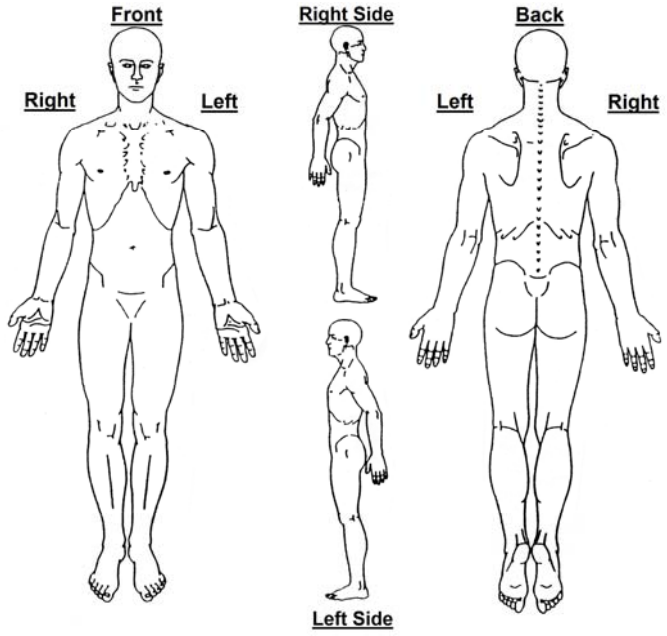
PLEASE PRINT NAME **(Relationship to client: self, guardian)**

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

☐ Disclose my information indefinitely (as long as *Movement For Life 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 *Movement For Life 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 *Movement For Life 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
_____ *Movement For Life 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**