NEW CLIENT FORM

PLEASE PRINT CLEARLY

Injury Type: ☐ Home *Please complete boxes **A, C & D***
☐ Auto *Please complete **A, C, D & Accident Information Sheet*** Date of Injury:_____
☐ Work *Please complete **A, B, & C***
☐ Other: _____

A.

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

Home Address:_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____Cell/Other Phone:_____

Email Address: _____ Drivers Lic. # :_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Sex: M / F

Emergency Contact:_____Phone:_____ Relationship: _____

Referring Physician:_____Phone: _____

Referring Dr. Address: _____

Primary Care Physician: _____Phone: _____

Would you prefer text message, email, or phone call reminders of your upcoming visits?

☐ *Text Message (please fill in cell phone number above)* ☐ *Email (please fill in email address above)* ☐ *Phone Call*

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

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

Have you been hospitalized in the past 60 days? ☐ *Yes* ☐ *No*

If *Yes* to either question, who is your Home Healthcare Provider: _____

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

If Yes, where? _____

How did you hear about us? ☐ *Print-Ad* ☐ *TV* ☐ *Radio* ☐ *Athletic Training* ☐ *Client* ☐ *Community Event*
☐ *Direct Access* ☐ *Employer* ☐ *Friend/Family* ☐ *Gym* ☐ *Internet Search* ☐ *Mailer* ☐ *Referring MD*
☐ *Returning Client* ☐ *Self Referred* ☐ *Social Media* ☐ *Staff* ☐ *Website* ☐ *Yellow Pages* ☐ *Other*

B.

If Work Comp Claim**:** Employer at time of Injury:_____Phone:_____

Employer Address: _____

C.

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

D.

Primary Insurance:_____Subscriber Name:_____

Relationship to Client:_____ Subscriber: _____
ID # Date of Birth Group/Policy #

Secondary Insurance:_____Subscriber Name:_____

Relationship to Client:_____ Subscriber: _____
ID # Date of Birth Group/Policy #

Client/Guardian Signature:_____ **Date:**_____

Medical Screening Form

Name:_____ **Date:**_____ **Gender:** Male ☐ Female ☐
Age:_____ **Occupation:**_____ **Currently Working?** Yes ☐ No ☐

CURRENT CONDITION:
Where are you currently having symptoms?_____

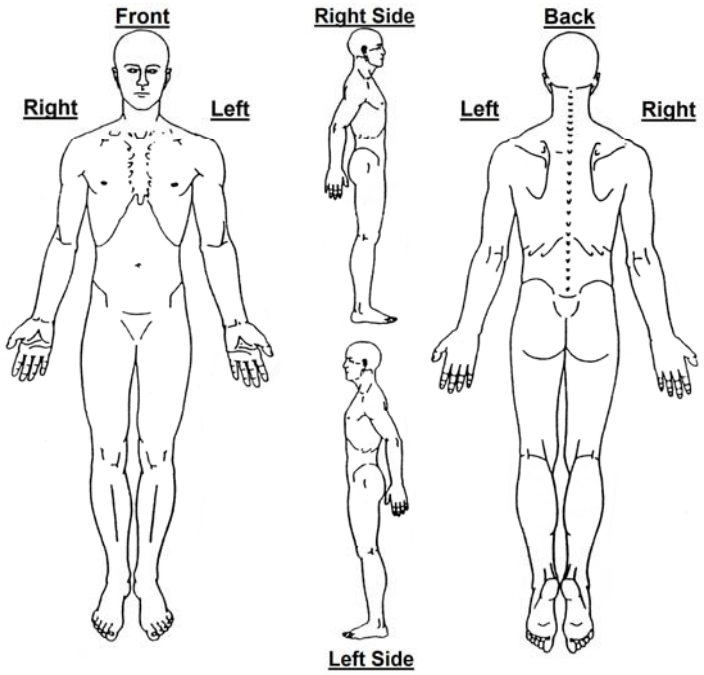
When did these symptoms start?_____
How did this injury occur? ☐ Gradually ☐ Suddenly ☐ Injury Please describe:_____

My symptoms are currently: ☐ Getting Better ☐ About the Same ☐ Getting Worse
Please list any previous treatment for the condition we are seeing you for today_____

Have you ever had this problem before? ☐ YES ☐ NO
If so, how was the problem treated?_____
Did that treatment help? _____
Have you had any imaging studies done for this problem (x-rays, MRI, etc)? ☐ YES, where:_____ ☐ NO

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem for which we are seeing you: _____

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



Circle the number that represents your pain rating at *present*:

No Pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Pain**

Circle the number that represents your pain rating at *best* over the past week:

No Pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Pain**

Circle the number that represents your pain rating at *worst* over the past week *(if you have time with no pain, please note 0):*

No Pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Pain**

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

☐ Headaches
☐ Increased Pain at Night
☐ Fever / Chills / Sweats
☐ Changes in Appetite
☐ Difficulty Swallowing
☐ Unexplained Weight Loss/Gain
☐ Nausea / Vomiting
☐ Numbness or Tingling
☐ Dizziness
☐ Changes in Bowel or Bladder Function
☐ Depression
☐ Shortness of Breath
☐ Other_____

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
☐ Lung Disease/Problems
☐ Heart Disease/Problems
☐ Asthma/Allergies
☐ Circulation/Bleeding Problems
☐ Stroke
☐ Cancer
☐ Liver Disease
☐ Pacemaker
☐ Osteoporosis
☐ Arthritis
☐ Kidney Disease
☐ Diabetes ☐ before age 18 ☐ after age 18
☐ Angina
☐ Fibromyalgia

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

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

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 past surgeries (or injuries) and dates:

_____

_____

_____

Please list any medical conditions you have that have not been documented above:

_____

_____

What are your physical therapy and/or fitness goals (write out or complete the sentence that applies to you)?

_____

☐ Decrease pain with _____

☐ Improve ability to _____

Are you currently physically active? ☐ YES ☐ NO

Client Signature: _____ **Date:** _____

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.

Signature: _____Date:_____

Patient, Parent or Patient's Representative

If other than patient, please specify relationship: _____

ACUSO DE RECIBO DE LA NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

Al firmar este formulario, usted acusa recibo de la Notificación de las Prácticas de Privacidad de Movement for Life clinics. Nuestra Notificación proporciona información sobre cómo podemos usar y revelar la información médica que mantenemos sobre usted. Le exhortamos a leer nuestra Notificación completa. Si usted tiene cualquier pregunta sobre nuestra Notificación de Prácticas de Privacidad que nuestro personal en la sección de registro no pueda contestar, por favor póngase en contacto con nuestra Oficina Privacidad al 805-788-0805 ó en el 1106 Walnut Street, #110, San Luis Obispo, CA 93401.

Firma: _____Fecha/Date: _____

Paciente, Padre, Representante Personal

De ser otra persona que el paciente, especifique la relación: _____

FOR OFFICE USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If the clinic is not able to obtain the patient's acknowledgement, please complete the following:

Reason acknowledgement was not obtained:

☐ Patient refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ Patient unable to sign

☐ Other:

_____

_____

Staff Signature: _____

Print Name: _____ Date: _____

OFFICE POLICY

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 as I go. 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)
- ☐ I understand that my employer is required to provide pre-payment for my treatment prior to my visit. Any visits missed or not used by the end of treatment will not be refunded. _____ (please initial)

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

PATIENT / GUARDIAN / RESPONSIPLE PARTY SIGNATURE **DATE**

CONSENT FOR CARE & TREATMENT: Your Physical Therapist 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 **Score Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR TREATMENT OF A MINOR: I authorize **Score 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. _____ (parent/guardian initial)

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

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges 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 for a physical therapy 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.

_____ _____

PATIENT / GUARDIAN SIGNATURE **DATE**

_____ _____

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

Payment Options

Online Payments: www.movementforlife.com/payment
Cash, Check, Visa, MasterCard, AMEX, Discover

Pay-As-You Go ~ Pay your co-pay plus an estimated portion of your unmet deductible and co-insurance at each visit.

- We provide a summary of your estimated costs based on a verification of your benefits, our contract with your insurance and the average treatment rendered.
- We will bill your insurance, and will await your insurance company's notification* to us of your balance due (client responsibility). We will then bill you monthly for your remaining balance due. In the event of overpayment, we will issue you a refund once your insurance has acknowledged all of your claims for your treatment.

***Please Note:** The Insurance Companies determine our rates and your balance due except for our cash rate patients. Clients initial statements may be delayed up to several months as we work with your insurance company to cover your treatment according to your benefits and determine the correct patient responsibility.

Auto/MVA ~ We accept 1st party auto insurance plans only.

(Policy belonging to the patient)

- If you are seeking reimbursement for treatment, or the auto policy does not belong to you there are two options:

1. If you are planning to pursue reimbursement from another party's policy, you may pay the non-discounted charge for treatment and request an itemized statement that you can then submit to the other party's policy for reimbursement.

Or

2. You may pay the cash rates. Please see details below.

Cash Rates ~ Pay our discounted cash rates at each visit.

- These amounts will NOT be billed to your insurance. We do NOT provide itemized statements for this option.

Rates: $125/Initial visit with Evaluation

$90/Regular visit

You may not change to or from this option during your course of care

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) **Patient's Printed Name**:

_____
Last First Initial or Other

Date of Birth: ____/_____/_____

(2) Score PT will only disclose the protected health information you want disclosed.
Check only one box to tell Score PT 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 Score PT can use this authorization:

☐ Disclose my information indefinitely (as long as Score PT 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 Score PT 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 Score PT 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
_____ Score PT 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 Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

You May Refuse to Sign this Authorization