



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 previously had physical therapy/speech therapy/chiropractic treatment under this claim? Yes No

If yes, where? _____

EMPLOYER/WORKERS' COMPENSATION INFORMATION

Employer at time of Injury: _____ Phone: _____

Employer Address: _____

Attorney Involved? Yes No Attorney Name: _____ Phone: _____

Attorney Address: _____

Work Comp Insurance Carrier: _____

Adjustor's name: _____ Phone: _____

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: If you are a workers' compensation patient, it is our policy to bill your employer or the workers' compensation carrier for services rendered. If you are covered under workers' compensation, we will accept the payments by the workers' compensation carrier as per contracted rates based on the mandated state fee schedule. If your claim is denied by workers' compensation, you will be responsible for the balance due. It is your responsibility to provide us with your employer's information including their workers' compensation carrier/insurance company.

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.

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. Worker's Compensation claims require us to report missed visits that occur without notification, multiple missed appointments can lead to revoked authorization.

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)

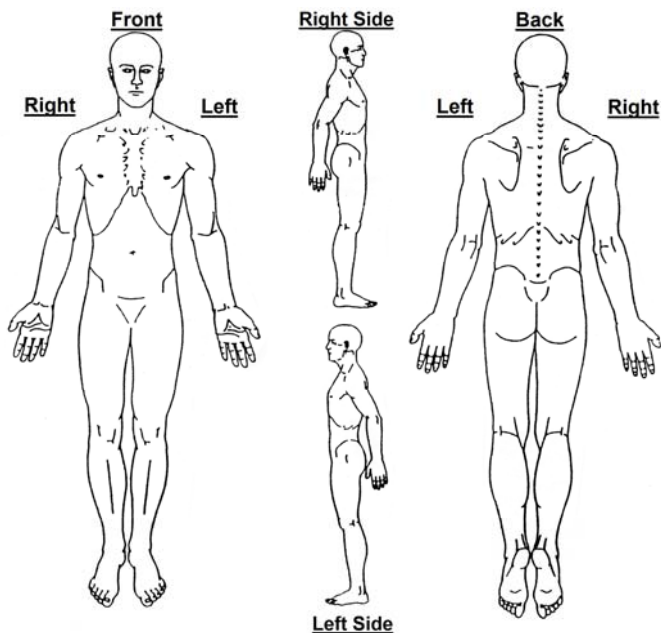


Medical Screening Form

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
<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:



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

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

You May Refuse to Sign this Authorization