# 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 previously had physical therapy/speech therapy/chiropractic treatment under this claim? ☐ 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?_____

## 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 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.

**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.

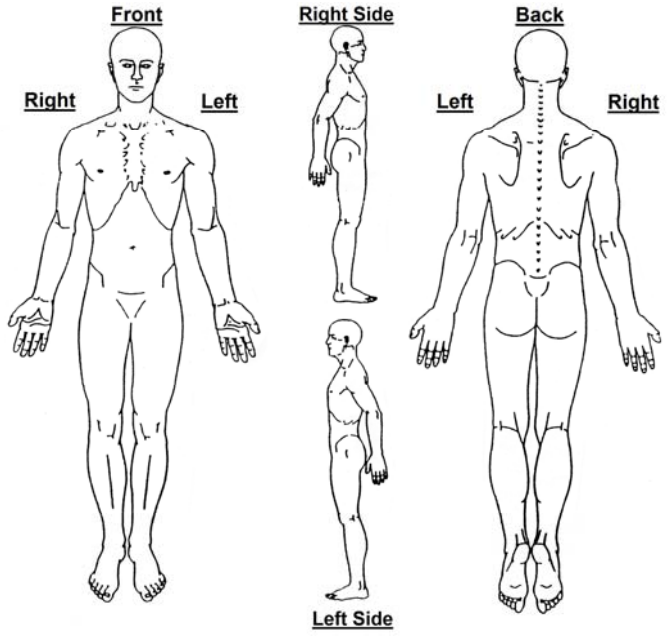
| | |
|---|---|
| **CLIENT / GUARDIAN SIGNATURE** | **DATE** |
| **PLEASE PRINT NAME** | **(Relationship to client: self, guardian)** |

# 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):**

| | | | |
|---|---|---|---|
| ☐ 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**