EMPOWER
PHYSICAL THERAPY & WELLNESS

NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:_____

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

Birth Date_____ Age _____ Sex: _____

Home Address_____

City_____ State_____ ZIP_____

Area to be treated_____ Injury Date _____

Cell Phone _____ Phone _____ _Work Phone _____

Email _____

How shall we contact you? (circle) ☐ Cell Ph. / ☐ Home Ph. / ☐ Work Ph. / ☐ Email

Status ☐ Married / ☐ Single / ☐ Divorced / ☐ Separated / ☐ Widowed **Student** ☐ No / ☐ Full-time / ☐ Part-time

Employment Full / Part-time / Not Working / Retired **Employer**_____

Emergency Contact_____ Relation_____ Phone_____

Referring Physician_____ Telephone _____

How did you hear about us?

☐ Friend/Relative _____ ☐ Internet ☐ Yelp ☐ Facebook ☐ Physician ☐ Other_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____ Is an attorney involved? ☐ Yes / ☐ No

Patient Signature: _____ **Date:**_____

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MEDICAL HISTORY

Patient Name _____

Age _____

Type of Injury / Condition _____

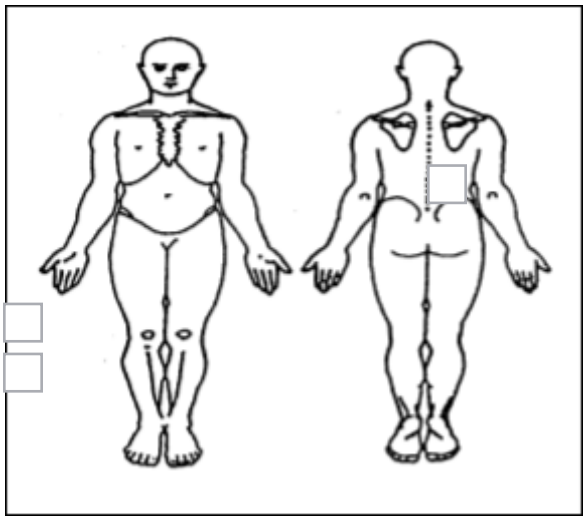
Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment _____

Describe previous treatment for this condition _____

Please mark the area(s) of concern



Have you received physical therapy treatment this year? ☐ Yes / ☐ No

Have you received speech therapy treatment this year? ☐ Yes / ☐ No

Have you received Home Health Care via Medicare this year? ☐ Yes / ☐ No

Have you had any imaging performed? :

☐ X-Ray ☐ CT Scan ☐ Ultrasound

☐ MRI ☐ Doppler

Have you recently noted any of the following? :

☐ Weight Loss /Gain ☐ Nausea / Vomiting ☐ Fatigue

☐ Weakness ☐ Fever / Chills / Sweats ☐ Numbness / Tingling

☐ Pregnant / IUD ☐ Headaches ☐ Change In Vision or Hearing

☐ Pain at Night ☐ Cramps in Legs When Walking ☐ Insomnia

Do you have now or have you ever had any of the following? :

☐ Surgeries ☐ Loss of Consciousness ☐ Fractures

☐ Sprains / Strains ☐ Diabetes ☐ Blood Pressure Problems

☐ Heart Problems ☐ Cancer ☐ Motor Vehicle Accident

☐ Circulation Problems / Clots ☐ Asthma / Breathing Problems ☐ Lung Disease

☐ Easy Bruising / Bleeding ☐ Leg / Ankle Swelling ☐ Urinary Problems / Infections

☐ Indigestion / Heartburn ☐ Fainting ☐ Allergies / Skin Sensitivity

☐ Any previous injury that may affect current care _____

Please explain & give approximate dates for any items indicated above _____

Are you currently taking medications? ☐ Yes / ☐ No Name or Type of Medication: _____

Type of Pain: ☐ Sharp / ☐ Burning / ☐ Aching / ☐ Tingling / ☐ Numbness / ☐ Other _____

Rate your pain: (1=minimal / 10=severe) At its **worst**: 1 2 3 4 5 6 7 8 9 10 ☐

At its **best**: 1 2 3 4 5 6 7 8 9 10 ☐

How important is it for you to get out of pain? (1=not important / 5=very important) ☐ ☐ ☐ ☐ ☐ 1 2 3 4 5

What do you hope to get out of your treatment? _____

What are your physical or fitness goals? : _____

Patient Signature _____ **Date** _____

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OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Empower Physical Therapy and Wellness** to treat the minor patient named in the attached forms while I am not present.

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 **Empower Physical Therapy and Wellness** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

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

NOTICE OF CHANGE IN INSURANCE: It is the responsibility of the patient to notify **Empower Physical Therapy and Wellness** of any changes in insurance carrier/coverage as soon as possible. The patient will be responsible for any denied claims due to change/lapse in insurance coverage.

Patient/Guardian/Responsible Party _____ **Date** _____

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.

Patient/Guardian/Responsible Party _____ **Date** _____

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. Per the contractual obligations, we have with your insurance company, we are required to collect all payments at the time of treatment unless payment arrangements are made prior to your treatments. 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. **Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation.**

Medi-Cal Insurance Policy: We are **NOT** a contracted provider with Medi-Cal. We do accept patients with Medicare primary insurance and Medi-Cal secondary insurance. However, any other primary insurance with Medi-Cal as a secondary will not be accepted and you will be financially responsible for the full amount of services rendered.

Patient/Guardian/Responsible Party _____ **Date** _____

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PRIVACY POLICY: I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Empower Physical Therapy to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Patient/Guardian/Responsible Party _____ **Date** _____

24 HOUR CANCELLATION POLICY & REMINDERS

To Our Patients Regarding Cancellations and No Shows:

- We require a 24-hour notice in the event of a cancellation. It is your responsibility, when you call, to have an alternate time in mind that will ensure you attend the entire number of prescribed treatments for each week.

- When you do not attend as scheduled, three people are being hurt by the action:
  - 1) you--because you did not receive your treatment as prescribed;
  - 2) the therapist—who scheduled the time for you, and your treatment;
  - 3) another patient who could have been scheduled if proper notice was given.

- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your Case Manager, and Primary Physician and this can jeopardize your claim.

In an instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, we reserve the right to charge a $50 fee.

1. After the 1st offense a courtesy reminder will be given.

2. After the 2nd offense there will be a fee of **$50** (not covered by insurance) and will remain for all subsequent infractions.

3. Cancellation and No-Show fees are to be paid prior to the following appointment. You may not be able to be treated until fees are paid.

4. In addition, 3 offenses without payment may result in the loss of your physical therapy benefits. We reserve the right to cancel all future appointments and withhold scheduling future appointments.

_____ _____

Patient (Guardian) Signature: **Date:**

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Text/Email Reminders

I consent to Empower Physical Therapy and Wellness contacting me by text and/or email message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text/email may not take place on all occasions, and that the responsibility of attending appointments or rescheduling them still rests with me.

Patient (Guardian) Signature: _____

Date: _____