[ ] West Los Angeles [ ] Westlake Village [ ] Simi Valley [ ] Encino

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone-Home: ( ) _____-_____ Work: ( ) _____-_____ Mobile: ( ) _____-_____

Social Security No.: _____-_____-_____ ☐ Male ☐ Female Referring Physician: _____

Employer/School: _____

Occupation/Sport: _____ E-mail: _____

Have you provided Athletic PT with your current primary and secondary health insurance information? ☐ Yes ☐ No

SPOUSE OR PARENT/GUARDIAN: ☐ N/A

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Business Phone: ( ) _____-_____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ Phone: ( ) _____-_____

INJURY HISTORY:

How did the injury/symptoms occur? _____

_____

When did the injury or symptoms first appear? _____

What are your current symptoms (pain/burning/numbness ache) and where are they on your body? _____

_____

What is your average daily pain over the past week 1-10? (0 is none and 10 is severe) _____

Did you have x-rays/MRI/CT scan of this body part and what were the findings? _____

_____

Have you had surgery for this condition and when? _____

_____

Patient's Signature: _____ Date: _____/_____/_____

Patient/Responsible Party Name: _____

Assignment of Benefits

_____ (initial) I hereby authorize, Athletic Physical Therapy, Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS, to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Athletic Physical Therapy Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS, directly for services rendered.

Cancellation/No Show Policy

_____ (initial) There will be a $25 charge directly to the patient for all appointments that are not cancelled 24 hours BEFORE the scheduled appointment time or if the patient does not show up for their appointment "no show".

Notice of Privacy Policies

_____ (initial) I have received/reviewed a copy of Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc Health Information Privacy Policies.

Consent to Treatment

_____ (initial) I give consent for Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc to treat my condition within the scope of practice defined by the American Physical Therapy Association Practice Act and the Licensing Board of the Department of Consumer Affairs. Treatment is administered based on the physician's diagnosis and requires a prescription throughout the plan of care. It is my responsibility to provide Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc with these prescriptions as needed. I also understand that if I wish to stop treatment at any time for any reason, I must simply tell my therapist to stop or adjust treatment to my preference. If I have any complaints about the treatment I am receiving, I should ask and will receive the contact information for the Clinical Director, Stephen Clark, PT, DPT, OCS.

Payment for Services

_____ (initial) Private pay, co-payment, co-insurance and/or deductible payments are required each treatment. It is my responsibility to make these payments in order for me to continue with my treatments. I understand that every attempt will be made by Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc to collect the proper amount however I understand that I may receive an additional bill in the event that my insurance company does not process claims in the same manner as was quoted to Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc. I also agree that anything an Athletic Physical Therapy, Inc /Get Fit Physical Therapy, Inc employee or representative says about my health insurance benefits is speculation and it is my responsibility to check what benefits are available for services.

Credit Card on File

_____ (initial) It is required that all private pay patients, patients owing an insurance co-payment, co-insurance and/or deductible provide their credit card or debit card information and hereby authorize Athletic Physical Therapy, Inc. /Get Fit Physical Therapy, Inc. /Stephen Clark, DPT, OCS to charge me only for the agreed amount for services rendered as stated on the verification of benefits. By signing below, I agree to allow Physical Therapy, Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS, to charge my credit card for the services rendered. I understand that this information is to be kept private and secured by Athletic Physical Therapy, Inc. / Get Fit Physical Therapy, Inc. / Stephen Clark, DPT, OCS.

Cardholder Name: _____

Credit Card Type: VISA/MC Card Zip Code: _____ Card CSV Code:_____

Account Number: _____ Expiration Date: _____

Signature of Authorized Card Holder: _____

General Health Questionnaire

Do you currently experience any of these symptoms?

1.	Fevers/Chills/sweats	_____ Yes	_____No
2.	Unexplained weight loss/gain	_____ Yes	_____No
3.	Malaise (feeling generally unwell)	_____ Yes	_____No
4.	Unusual fatigue	_____ Yes	_____No
5.	Nausea/Vomiting	_____ Yes	_____No
6.	Numbness/tingling	_____ Yes	_____No
7.	Weakness	_____ Yes	_____No
8.	Dizziness/lightheadedness/loss of consciousness	_____ Yes	_____No
9.	Chest pain/palpitations	_____ Yes	_____No
10.	Swelling in feet or hands	_____ Yes	_____No
11.	Difficulty breathing/shortness of breath	_____ Yes	_____No
12.	Difficulty breathing when lying down	_____ Yes	_____No
13.	Cough/change in cough/blood in phlegm	_____ Yes	_____No
14.	Wheezing	_____ Yes	_____No
15.	Difficulty with swallowing	_____ Yes	_____No
16.	Heartburn/Indigestion	_____ Yes	_____No
17.	Change in appetite	_____ Yes	_____No
18.	Specific food intolerance/nausea/vomiting	_____ Yes	_____No
19.	Bowel pattern changes (color, texture, frequency)	_____ Yes	_____No
20.	Difficulty urinating (starting/stopping)	_____ Yes	_____No
21.	Urine frequency changes	_____ Yes	_____No

Do you have any other medical issues or previous medical conditions not mentioned above?

_____

_____

Please list your current medications: _____

_____

Are you allergic to any medications (cortisone/menthol)? _____

What medical conditions exist in your parents' (birth mother and father) medical history?

_____

Please Print Your Name: _____