New Life Physical Therapy
Sports Medicine & Therapy Center

• Physical Therapy • Sports Injuries
• Aquatic Therapy • Work Injuries

GENERAL PATIENT INFORMATION

(THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL)

DATE_____

_____ _____ _____ (_____)_____
PATIENT'S LAST NAME FIRST NAME MIDDLE HOME PHONE

_____ _____ _____ _____
CURRENT STREET ADDRESS CITY STATE ZIP HOW LONG

_____ _____ (____)_____ _____ (____)_____
SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER WORK PHONE EXT. CELL PHONE

_____ _____
EMPLOYED BY EMPLOYER'S ADDRESS

_____ _____ _____ SEX: ☐ MALE ☐ FEMALE
OCCUPATION DATE OF BIRTH AGE

EMAIL ADDRESS: _____ MAY WE USE YOUR EMAIL ADDRESS TO CONTACT YOU REGARDING YOUR APPOINTMENT SCHEDULE? ☐ YES ☐ NO NOTE: WE DO NOT SHARE ANY PATIENT INFORMATION, ONLY NEW LIFE WILL UTILIZE YOUR EMAIL.

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

_____ _____ (_____)_____
NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY RELATIONSHIP EMERGENCY PHONE

_____ _____ _____ _____
CURRENT STREET ADDRESS CITY STATE ZIP

WHO REFERRED YOU TO THIS OFFICE_____

INSURANCE ASSIGNMENT

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY IRREVOCABLY ASSIGN AND TRANSFER ALL BENEFITS WHETHER CONTRACTUAL, STATUTORY OR COMMON LAW TO NEW LIFE REHABILITATION, INC. FOR ALL AMOUNTS DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AM AWARE OF THE FACT THAT VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT AND THAT I AM FULLY RESPONSIBLE FOR PAYMENT IN FULL IN THE EVENT MY INSURANCE CARRIER(S) DOES NOT COVER ANY OR ALL INCURRED CHARGES AT NEW LIFE REHABILITATION, INC.

OUR OFFICE WILL BILL YOUR INSURANCE CARRIER(S) AS A COURTESY TO YOU. IF YOUR INSURANCE CARRIER SENDS PAYMENT DIRECTLY TO YOU, YOU WILL BE RESPONSIBLE TO FORWARD THESE PAYMENTS TO OUR BUSINESS OFFICE IMMEDIATELY UPON RECEIPT. ALL PATIENT BALANCES 60 DAYS PAST DUE WILL BE ASSESSED A FINANCE CHARGE.

_____ _____
RESPONSIBLE PARTY'S SIGNATURE DATE

ADMISSION FORM

History and Physical Condition Information

Answers to the following questions will assist the Therapist in providing a safe and effective program.

NAME:_____AGE:_____

Referring Physician:_____Today's Date:_____

Primary Care Physician: _____ Best Contact Phone#:_____

Problems to be treated:_____

Have you had treatment for this problem before? YES NO

If YES, where:_____When:_____

Treatment given:_____

Have you had surgery associated with this problem? YES NO

If YES, please list date and type of surgery: _____

List any other major illness or surgery that has occurred in the past year: _____

Have you fallen in the past year? YES NO

Are you currently taking any medications? YES NO

If YES, please list ALL medications: _____

Have you ever had Physical Therapy before? YES NO

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

High Blood Pressure	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Episodes of Dizziness	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Incontinence	YES	NO

If YES on any of the above, please explain and give approximate dates:_____

_____

If Yes to High Blood Pressure, are you taking medication: YES NO.

Has a doctor ever told you that have a medical condition that requires you to restrict your cardiovascular exercise: YES NO.

Who referred you New Life: Friend Family Doctor Self Other_____

_____

The above information is correct to the best of my knowledge.

Patient Signature:_____ Date:_____

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PATIENT NAME_____ DATE_____

PAIN EVALUATION

PAIN DRAWING

Use the symbols below to mark the areas on your body where you feel the following sensations. Include ALL affected areas.

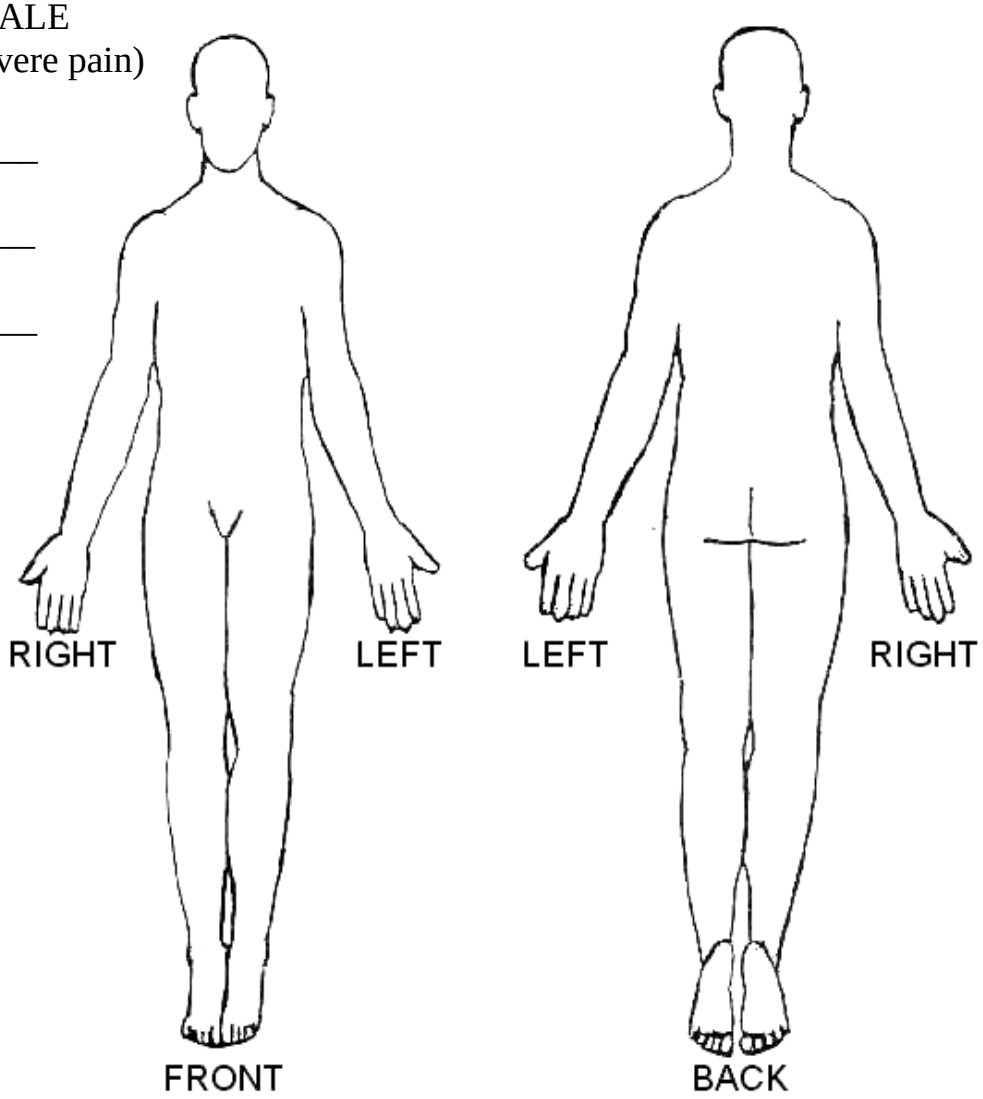
BURNING	NUMBNESS	PINS & NEEDLES	STABBING	ACHE
X	**O**	**=**	**/**	**^**

PAIN LEVEL SCALE
(0 no pain – 10 severe pain)

AVERAGE: _____

BEST: _____

WORST: _____



Therapist's Signature_____ Date_____

17122 Beach Blvd., Suite 101 Huntington Beach, CA 92647-5907 (714) 848-7191 FAX (714) 375-7563

Late Cancellation and No Show Policy

Effective March 1, 2018

Our goal is to provide quality physical therapy in a timely manner. When appointments are missed or cancelled without timely notice it leaves openings that could be used by other patients.

We make every effort to remind you of your appointments. It is necessary for you to cancel your appointment in a timely manner.

Therefore, we require that you notify us at least 24 hours in advance. This allows us time to allocate that appointment to another patient. You can leave a message on the machine if no one is available to pick up when you call to notify us.

If timely notification is not given, or if you fail to show up for your appointment, you will be charge a $25.00 fee.

Thank you for your cooperation.

I agree to the cancellation and no show policy listed above.

Patient Signature_____

Date_____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The following information is being furnished to you as required under the Standards for Privacy of Individually Identifiable Health Information published by the U.S. Department of Health and Human Services at 45 C.F.R. parts 160 and 164 under the Health Insurance Portability and Accountability Act of 1996. Contact information for the U.S. Department of Health and Human Services is contained at the end of this notice.

1. At New Life Rehabilitation, Inc. (New Life), we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to disclose your health information to those involved in your treatment. For example, we routinely share your continuing progress with your physician, to keep him updated as to your treatment here at New Life.
2. We may use or disclose your health information for payment of your services or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
3. We may use your information to contact you. We may want to call and remind you of appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
4. If this practice is sold, your information will become the property of the new owner. The new owner assumes the accountability for your protected health information.
5. Except as described above, the practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
6. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

7. You have the right to transfer copies of your health information to another practice. We will make copies available for you to pick up. A nominal fee may be charged for copying or mailing.

8. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

9. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

10. You have the right to receive a copy of this notice.

11. If we change any of the details of this notice, we will notify you of the changes in writing.

12. You may file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC. 20201. You will not be retaliated against for filing a complaint.

13. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (714) 848-7191.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have read and understand New Life Rehabilitation, Inc. Notice of Privacy Practices.

_____ _____

Signed Print Name

_____

Date

Consent to Treat Authorization

I,_____do herby consent to be treated for physical therapy by New Life Physical Therapy.

Patient Signature:_____Date:_____

Rev. 05/09