[ ] West Los Angeles [ ] Westlake Village [ ] Simi Valley [ ] Encino [ ] Thousand Oaks [ ] Oxnard

Patient Information

PATIENT DEMOGRAPHICS:

Name: ______________________________ Date of Birth: ____/____/______

Address: ____

City: ______________________________ State: ______ Zip Code: __________

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

Social Security No.: ____-____-____ ☐ Male ☐ Female Referring Physician: __________

Employer/School: ____

Occupation/Sport: ______________________ E-mail: ______________

SPOUSE OR PARENT/GUARDIAN: ☐ N/A

Name: ______________________ Relationship to Patient: ______________

Address: ____________________ City: __________ State: ____ Zip: ______

Employer: ____________________ Business Phone: ( ) ____-____

Date of Injury/Onset of Pain: ___/____/____ Date of Surgery for this Condition: ___/____/_____

Area(s) of pain and area(s) to be treated: ________________________________

____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name: ______________________________ Phone: ( ) _____-_____

INSURANCE INFORMATION:

Have you provided Athletic PT with your primary health insurance information? ☐ Yes ☐ No ☐ N/A

Have you provided Athletic PT with your secondary health insurance information? ☐ Yes ☐ No ☐ N/A

CANCELLATION POLICY:

Unless there is an emergency, we do not accept same day cancellations for scheduled appointments. _____ (initial)

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

ASSIGNMENT OF BENEFITS

Patient's Name: ____

Patient's Identification Number/Social Security: ______________________________

Patient Payment Responsibility: ____

Notice of Privacy Policies:

I have received a copy of Athletic Physical Therapy's Health Information Privacy Policies ________ (initial)

Consent to Treatment
I give consent for Athletic Physical Therapy 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 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.

I hereby authorize, Athletic 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. / Stephen Clark, DPT, OCS, directly for services rendered.

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.

Credit Card on File:
All private pay patients, patients owing an insurance co-payment, co-insurance and/or deductible need to provide their credit or debit card information and hereby authorize Athletic Physical Therapy, Inc /Stephen Clark, DPT, OCS to charge only for the agreed amount for services rendered as stated on the verification of benefits. By signing below, I agree to allow Athletic 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. / Stephen Clark, DPT, OCS.

Signature of Authorized Card Holder: ______________________________________

Cardholder Name: ____

Credit Card Type: ________________ Account Number:__________________________

Expiration Date: ____

Signed: ____________________________ Date: ___________________
(Patient or Legal Guardian)

Blue Shield, Motion Picture and Health Net Insurance Policy Holders:
When you receive your Explanation of Benefits from Blue Shield, it may be documented that payment was made to Get Fit Physical Therapy, Inc. This company is affiliated with Athletic PT and we will receive these payments on your behalf.
________ (initial)

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

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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

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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

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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 medications you are currently taking: ____

____

Are you allergic to any medications (cortisone?)____

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

____

Please Print Your Name: ____

1-7 General/8-13 CV/11-14 PS/15-18 GI (upper back/shd)/19 GI (low back)/20-21 UG