

**CORE Physical Therapy:**  
**Fullerton Orange Anaheim Hills Temecula**  
**New Patient Form**

**My insurance is an:** HMO PPO Medicare Work Comp Lien Other: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender Preference: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**Financially Responsible Party: (N/A if patient)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

**Insurance Information:**

Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Secondary Insurance:**

Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Language Preference:** \_\_\_\_\_ **Interpreter: Needed:** \_\_\_\_\_ **Refused:** \_\_\_\_\_

**Assignment of Insurance Benefits and Acknowledgments:**

1. Regardless of any third party contract agreement you feel we may have, the patient is ultimately responsible for any services rendered and/or products dispensed at or from CORE Physical Therapy. We will of course attempt to bill your insurance for any services rendered, but any balance or denied charges are the responsibility of the patient. You will also be responsible for any legal or collection fees incurred in collecting any unpaid balances.
2. If you would like us to bill your insurance, then it is understood that you hereby assign to CORE Physical Therapy any and all benefits from your insurance carrier.
3. By signing below you authorize CORE Physical Therapy to release any information necessary to insure processing of your billed claims. This includes but is not limited to any third party payors, attorneys, employers, etc...
4. Patient acknowledges that they have received a read the HIPAA Compliance Practices posted and have received a copy if one has been requested.
5. There is a \$35 cancellation fee for appointment not cancelled with 24 hrs notice. This will be charged after the third, (3<sup>rd</sup>), offense.

**Medicare patients only:** I confirm that I am NOT currently having home health services. I am aware that Medicare will not cover outpatient physical therapy and home health at the same time. **Initials:** \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature:**

\_\_\_\_\_  
**Date:**

**Release of Information**

I \_\_\_\_\_ hereby authorize the staff at CORE Physical Therapy, to release any medical, scheduling and/or billing information on me to the following individual(s) should they request it:

1. \_\_\_\_\_ is my \_\_\_\_\_ DOB: \_\_\_\_\_
2. \_\_\_\_\_ is my \_\_\_\_\_ DOB: \_\_\_\_\_
3. \_\_\_\_\_ is my \_\_\_\_\_ DOB: \_\_\_\_\_

This will serve for staff members to provide questions regarding the patients care, make or edit appointments or any financial concerns. This is not authorization for release of medical records. I release all CORE Physical Therapy staff members from any liability that may arise from the release of such information. Should I wish to obtain copies of my records, I will do so by signing a Records Release and paying for required fee. **Initials:** \_\_\_\_\_

### **Insurance Benefit Information**

Your insurance benefits have been quoted to us by your insurance company and we assume NO liability for any errors made by your carrier in their information provided. The fact that your insurance has been verified does NOT release you or is in no way in lieu of your responsibilities or our office. Your acceptance of medical care from our office will suffice as your agreement to the above in lieu of your signature provided.

### **Healthcare Directive**

Our office can have a healthcare directive available to you should you choose to sign one. Please let us know if you would like to complete one or if you would prefer to decline. **Decline: Yes No**

### **Consent for Treatment**

Knowing that I am suffering from a condition requiring diagnostic or medical treatment, I hereby consent to care by CORE Physical Therapy as they may deem necessary by their judgment. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by CORE Physical Therapy will meet customary standards. I do understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize CORE Physical Therapy to retain any records for use, for research and for teaching purposes. Should I choose to refuse treatment that has been suggested to me, I will not hold CORE Physical Therapy or any individual responsible for any consequences resulting from my decision.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this consent is signed by a representative or responsible party, please indicate the following:

**Responsible Party Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Injury Information**

**Is condition due to an injury?** Yes No **If no, skip to section B.** If yes, please see below:

Was the injury work related? Yes No Describe injury: \_\_\_\_\_

Did you notify employer? Yes No If so, who did you notify? \_\_\_\_\_

Claim #: \_\_\_\_\_ Phone#: \_\_\_\_\_

Are you still working? Yes No Describe duties: \_\_\_\_\_

**B. Was injury due to auto accident?** Yes No If yes, please see below:

Date of accident: \_\_\_\_\_ Auto Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Reported on: \_\_\_\_\_ Lien Signed: Yes No

Attorney name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Were you hospitalized?** Yes No Date: \_\_\_\_\_ Where: \_\_\_\_\_

**Have you had to have surgery?** Yes No Date: \_\_\_\_\_ Any other surgeries: \_\_\_\_\_

**Have you had any falls in the past 6 months?** Yes No Date: \_\_\_\_\_ Where: \_\_\_\_\_

**What other types of doctors/health care providers have you seen for this condition?** \_\_\_\_\_

**Have you had any of the following diagnostic tests?** X-rays: Yes No CT Scan: Yes No

MRI: Yes No Injections: Yes No

**Which activities make pain worse?** During Exercise After Exercise Sitting Walking Coughing  
Sneezing Bending Forward Bending Backward Other: \_\_\_\_\_

**How did pain start?** Suddenly Gradually Lifting Pulling Bending No Reason Other: \_\_\_\_\_

**Which of these reduces the pain?** Lying down Sitting Standing Walking Pain Injection Medication  
Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient or Responsible Party Signature:** \_\_\_\_\_

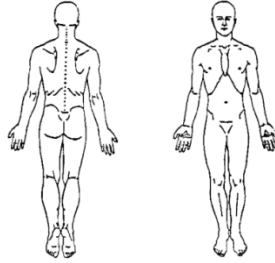
### Patient Health History

Patient Name: \_\_\_\_\_ Age: \_\_\_\_ Date: \_\_\_\_\_ When did pain start? \_\_\_\_\_

#### Pain/Symptoms:

On the body diagram, indicate you region of pain using these symbols:

(X) Sharp (+) Numb Tingling (#) Dull/Ache (B) Burn Pain is (0-10) \_\_\_\_\_



List all medications currently taking:      Dosage      Frequency      How Taken      Prescribed by:

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(If additional meds, please ask for 2nd page)

#### Do you have any of the following? (Please circle all that apply)

- |                     |                    |                              |                          |         |
|---------------------|--------------------|------------------------------|--------------------------|---------|
| Allergies           | Diabetes           | High Blood Pressure          | Heart Disease            | Stroke  |
| Cancer/Tumors       | Lung Problems      | Arthritis/Joint Difficulties | Fever/Chills             | Fatigue |
| Frequent Cramping   | Visual Problems    | Immunity Disorders           | Night Sleep Disturbance  |         |
| Pacemaker           | Joint Replacement  | Change in Bowel Habits       | Memory Changes           |         |
| Pain 24 Hrs         | Awake in Pain      | Increased Thirst             | Change in bladder habits |         |
| Nausea/Vomiting     | Increase in hunger | Indigestion /Heartburn       | Change in stool color    |         |
| Weakness            | Rectal bleeding    | Frequent urination           | Frequent Bruising        |         |
| Dizziness/Blackouts | Seizures           | Nerve Disorders              | Frequent Bleeding        |         |

(Ir)regular Headaches    Pregnant

Smoke: Yes No \_\_\_\_\_/day    Drink Yes No \_\_\_\_\_/day