C·O·R·E
PHYSICAL THERAPY

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ANAHEIM HILLS
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New Patient Form

New Patient: ☐ HMO ☐ PPO ☐ Medicare ☐ Work Comp ☐ Lien ☐ Other

Name: _____ Date: _____

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

Home Phone: _____ Cell: _____ Work: _____ Email: _____

Social Security: _____ DOB: _____ Gender: _____ Drivers License #: _____

Referring Physician: _____ Phone: _____ Primary Care Physician: _____

Marital Status: _____ Employer: _____ Occupation: _____

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

Emergency Contact: _____ Contact Number: _____

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

Financially Responsible Party: (If not patient)

Name: _____ Relationship: _____

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

Home Phone: _____ Cell: _____ Work: _____

Social Security #: _____ DOB: _____ Gender: _____

Insurance Informaiton:

Insurance Co: _____ Phone #: _____

ID#: _____ Group #: _____

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

Secondary Insurance:

Insurance Co: _____ Phone #: _____

ID#: _____ Group #: _____

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

_____ _____

Patient Signature Date

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Insurance Benefit Information

We will be happy to review these benefits with you and you as the patient agree to pay any remaining balance after your carrier has paid our claims. 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. We will be happy to review these benefits with you and you the patient agree to pay any remaining balance remaining after your carrier has paid our claim(s). The fact that your insurance has been verified does NOT release you or is in no way in lieu of your payment responsibilities to our office. Your acceptance of medical care from our office will suffice as your agreement to the above in lieu of your signature if not provided.

_____ _____

Patient/Parent/Responsible Party Date

Assignment of Insurance Benefits & 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/Fullerton Wellness Center. 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 copy and read our HIPAA Compliance Practices and has received a copy if requested.

_____ _____

Patient/Parent/Responsible Party Date

(Please check with our front office staff if you have any further questions. Thank you)

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Cancellation/No Show Policy

Successful rehabilitation depends not only on the skill of your Physical Therapist, but on the commitment, attendance and efforts of you the patient as well! At CORE Physical Therapy we have always prided ourselves on working with our patients in a timely manner so that the therapy process has the most minimal impact in our patients precious time. In addition, your timely attendance is important to facilitating short wait times and optimal patient flow.

The staff at CORE Physical Therapy is committed to accommodating your scheduling needs. In return, CORE Physical Therapy expects 24 hours notice prior to rescheduling or canceling of an appointment. We understand that patients can become ill on occasion or that work or other family/life circumstances can arise. Therefore, we will allow for two (2), no show or last minute cancellations to assist patients with this process. However, patients who chronically cancel or do not show for appointments, will be assessed a $35.00 cancellation/no-show fee on the third, (3rd), offense. Our office has set this time aside to accommodate your requested schedule and without the proper notice we are unable to provide the opportunity to another patient who may have requested the same time.

Thanking you in advance for your understanding.

Sincerely,

Matthew Reekstin MPT, MBA

I have read the cancellation policy and understand that I will be responsible to pay a cancellation/no show fee of $35.00 as indicated above.

_____ _____

Patient/Responsible Party Signature Date:

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Consent for Treatment

Consent for Physical Therapy: 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, under the prescription of a licensed physician. 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.

If I refuse treatment that is suggested for me, I will not hold CORE Physical Therapy or any individual responsible for any consequences resulting from my decision.

I, _____, have had full opportunity to read and consider the contents of this Consent for Treatment. I understand that, by signing this Consent form, I am giving my consent to treatment and attest that I am aware and understand all of the above.

Patient Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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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:_____

I understand that this will **not** provide authorization for copies of records. This release will serve in the capacity of the above-mentioned individual(s) needing to ask questions regarding my care, make or edit appointments or have questions regarding my financial status. I release all CORE Physical Therapy staff members from any liability that may arise from the release of any such information. I understand that if I would like to request copies of my medical records at any time, I will need to sign a Records Release Form and pay the required fee.

_____ _____

Patient Signature: Date:

_____

Witness:

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Patient Health History

Patient's Name: _____ Patient's Age: _____ Date: _____

Patient's Occupation: _____ When did the pain start? _____
(Approximate Date)

PATIENT HISTORY

How did the pain start?
- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other

What activities make the pain worse?
- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?
- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing
- ☐ Other

How long have you had this pain?
_____ Years _____ Months _____ Weeks

How long have you had similar pain?
_____ Years _____ Months _____ Weeks

Have you ever had any of these diagnostic tests?

X-rays	☐ Yes	☐ No	Date _____
CT scan	☐ Yes	☐ No	Date _____
EMG/NCV	☐ Yes	☐ No	Date _____
MRI	☐ Yes	☐ No	Date _____
Arthrogram	☐ Yes	☐ No	Date _____
Injections	☐ Yes	☐ No	Date _____

Have you been hospitalized for your problem?
☐ Yes ☐ No Date _____

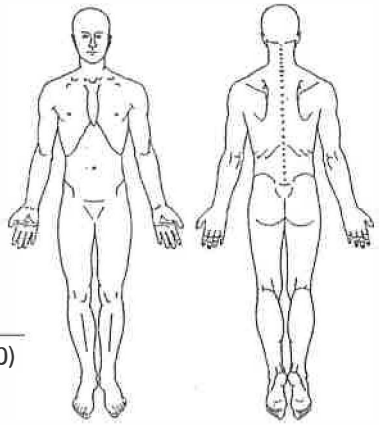
Have you had surgery for your problem?
☐ Yes ☐ No Date _____

Have you had any other surgery performed?
☐ Yes ☐ No Date _____

Pain/Symptoms
On the body diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning

_____
Pain Level (0-10)



What medications are you currently taking?

_____

Yes/No		
☐	☐	Allergies
☐	☐	Diabetes
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Stroke (CVA)
☐	☐	Cancer or tumors
☐	☐	Lung problems
☐	☐	Arthritis/joint difficulties
☐	☐	(lr)regular headaches
☐	☐	Dizziness/blackouts
☐	☐	Seizures/nerve disorders
☐	☐	Visual problems
☐	☐	Immunity disorders
☐	☐	Gout
☐	☐	Are you pregnant?
☐	☐	Joint replacement
☐	☐	Night sleep disturbance
☐	☐	Pacemaker

Yes/No		
☐	☐	Change in bowel or bladder habits
☐	☐	Change in stool color or rectal bleeding
☐	☐	Increased thirst or hunger
☐	☐	Frequent urination
☐	☐	Indigestion or heartburn
☐	☐	Nausea or vomiting
☐	☐	Changes in memory
☐	☐	Unusual fatigue/weakness
☐	☐	Fever or chills
☐	☐	Frequent or easy bruising or bleeding
☐	☐	Frequent cramping
☐	☐	Do you have pain 24 hours?
☐	☐	Do you awaken from pain?
☐	☐	Do you smoke? ____ #/day
☐	☐	Do you drink? _____ #/day

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

_____

_____

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Injury Information

Is condition due to an injury? ☐ Yes ☐ No When was the injury? _____

Was the injury work related? ☐ Yes ☐ No Was the injury due to auto accident? ☐ Yes ☐ No

Describe accident: _____

_____

Did you notify your employer? ☐ Yes ☐ No If so, who? _____

Their contact number: _____ Claim #: _____

Address: _____

Are you still working? ☐ Yes ☐ No Employer: _____

Phone #: _____ Address: _____

Describe your job responsibilities: _____

_____

Is condition due to surgery? ☐ Yes ☐ No Date of surgery? _____

Surgery performed: _____

Is there any litigation involved? ☐ Yes ☐ No Attorney Name: _____

Phone #: _____ Address: _____

Patient Name: _____ Date: _____

Patient/Responsible Party Signature: _____