

Comprehensive Therapy Services, Inc.

858.457.8419

New Patient Information

Patient's name: _____ Email Address: _____

Age: _____ Sex: M F Height: _____ Weight: _____ Marital Status: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____ Work Phone Number: _____

Address: _____ City/State/Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____

Spouse (or parent, if minor): _____

Contact person Outside Home: _____ Phone Number: _____

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Do you wish to receive emails with special offers/newsletters? Yes No

Billing Information (Please present insurance card)

Workers Comp _____ Auto Accident _____ Medicare _____ CIGNA _____ HealthNet _____ Aetna _____ Other _____

If you want us to bill under workers comp or for an auto accident, we will do so but we ask that you present us with your personal health insurance information as back up. I do not wish to provide a copy of my private health insurance card. I realize that if my workers comp or auto claim should be denied that I would be responsible for any charges incurred. Please Sign _____

CONSENT TO PHYSICAL THERAPY

1. I hereby authorize the release of medical information necessary to process my insurance. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim. I agree that a photocopy of this authorization is as valid as the original.
2. I authorize payment and assignment of my health insurance benefits directly to Comprehensive Therapy Services, Inc. I fully understand that I am financially responsible for any services not covered by this authorization.
3. I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending physical therapist. Your comfort is our priority. If you would like more privacy than our gym offers, treatment will be rendered in a private room. You may request a chaperone for your private treatment session as needed.
4. I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science. No guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.
5. ****NOTE TO WORKERS COMP**** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.
6. I understand, if I do not attend physical therapy for four weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the California State Law.
7. **"LATE FEES"** Patient balances due are to be paid once the insurance has processed and paid or denied your claims. If not paid timely, a \$25.00 late fee could be incurred. Co-pays are due at the time of service and are also subject to the late fee.
8. Children must be supervised. For safety reasons, children are not allowed in the therapy area.
9. Durable medical equipment may be suggested by your physical therapist. Insurance policies vary. Please be advised not all insurance companies cover DME, therefore, you may be responsible for payment.
10. I agree that in the event of non-payment of any patient balance due, I will bear all costs incurred for collection and/or court fees/legal fees required to satisfy the debt owed, should such court action be required.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACITON.

SIGNATURE OF PATIENT (if the patient is a minor, under 18 yrs of age, parent must sign)

DATE

Comprehensive Therapy Services, Inc.
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History and Physical Condition Information

Patient's Name: _____

Problem/Injury requiring physical therapy _____

Have you ever had treatment for this problem before? YES NO Physical therapy? YES NO

If YES, state when _____ Where _____

Have you had surgery associated with this problem? YES NO

If YES, please list date _____ Type of surgery _____

Please list any allergies you have _____

List all medications you are currently taking _____

Do you smoke? YES NO

Please mark appropriate answer if you have had or currently have any of the following. If yes, please indicate the date.

	YES	NO	DATE		YES	NO	DATE
High blood pressure	_____	_____	_____	Hernia	_____	_____	_____
Sensitive to heat/ice	_____	_____	_____	Seizures	_____	_____	_____
Heart attack	_____	_____	_____	Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____	Dizzy spells	_____	_____	_____
Balance Problems	_____	_____	_____	Headaches	_____	_____	_____
Kidney Problems	_____	_____	_____	Pacemaker	_____	_____	_____
Nervous Disorder	_____	_____	_____	Pregnant	_____	_____	_____
Hearing Problems	_____	_____	_____	Cancer	_____	_____	_____
Vision Problems	_____	_____	_____	Metal Implants	_____	_____	_____

Do you need assistance with any of the following? Circle appropriate answers

Transportation Shopping/Errands Domestic chores Meals Personal Care

Has your illness/disability caused any of the following? Circle appropriate answers

Financial problems Family Problems Emotional Problems Other _____

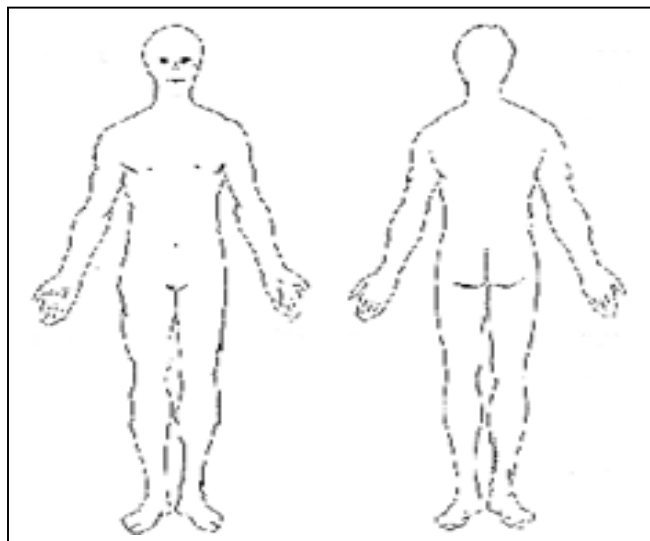
Please list any major illnesses _____

How did you hear about us? _____

Rate the intensity of your pain at its **best**: 0 1 2 3 4 5 6 7 8 9 10 and at its **worst**: 0 1 2 3 4 5 6 7 8 9 10
None Severe None Severe

Using the symbols given, mark the area on your body where you feel the described sensations. Include all affected areas.

Aching ^ ^ ^ ^ ^
Numbness = = = = =
Pins & Needles o o o o o
Burning x x x x x
Stabbing / / / / /
Other : : : : : :



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

Patient's Signature _____

Date _____