

**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**

