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**

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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 (None … Severe) and at its **worst:** 0 1 2 3 4 5 6 7 8 9 10 (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**
Burning	**X X X X**
Stabbing	/ / / / / / /
Other	**: : : : : : :**

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

Patient's Signature____ Date__________________________

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Worker's Compensation Insurance Form

Patient's Name:____ Date: ________________________
Employer: ______________________________________ Contact Person: ________________________
Have you notified your employer of this injury? Yes No Work Phone: ____________________
Has your employer authorized this treatment? Yes No
Date of Injury ____/____/____ Injury: ______________________________________
Are you currently working? Yes Light-duty or Full-duty No Date last worked: ________________

Claim Number: ___________________________
Adjuster: _________________________________
Adjuster's Phone: _______________________ Adjuster's Fax: _____________________

UR Contact: _______________________________________
UR Phone: _______________________ UR Fax: _____________________

Attorney's Name: _____________________________ Phone: ___________________________
Address: ____ City/State/Zip: _____________________

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

Patient's Signature:______________________________________ Date:_______________________