2727 E. Main St
Ventura, CA 93003
(805) 643-0171

New Patient Information Form

Please Print Clearly.

Date:_____

Name:(**First**)_____(**Last**)_____(**M.I**)___

Home Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Cell Phone: (_____)_____-_____ **Email Address:**_____

Appointment Reminders: Call: ____ or **Text: _____**

Date of Birth: (mm/dd/yyyy) _____/_____/_____ **Age_____ Sex:** M / F

Social Security Number: _____-_____-_____ **Marital Status:** Single / Married / Widowed / Other

Emergency Contact Name: _____ **Relationship**_____

Emergency Contact Number: (_____)_____-_____

Employment Status: Full / Part-Time / Unemployed / Self- Employed / Retired / Student **Employer Data:**

Address_____ **Phone:** (_____) _____ **Injury Type:**

Work / Auto / Home / Other_____

Is This A Work Related Injury? Yes_____ No_____

Primary Insurance _____

Insured Name_____ Insurance ID #_____D.O.B___/___/___

Who May We Thank For This Referral?

_____ The information above is true and correct to the best of my knowledge. I authorize my insurance company to make payment directly to Globerman Physical Therapy, Inc. I understand that I am responsible for all charges incurred in this office. I further authorize Globerman Physical Therapy to release any and all information concerning my care to my insurance company and my referring physician(s).

Patient or Guardian Signature:

X_____**Date:**_____

Medical Screening Form

Name:_____ Date:_____ DOB:_____/_____/_____

Height:_____ Weight:_____lbs Date of injury: _____/____/_____

Gender: M / F If female, post-menopausal? Y / N Date of last period:_____ Abnormal bleeding? Y/N Are you currently pregnant? Y / N If yes how far along? _____ Currently working? Y / N Occupation:_____ Work activities:_____ Have you recently received home health physical therapy? Yes No If yes, when? _____

Past Medical History: please mark all that apply

high blood pressure O	heart disease O	Diabetes Type I, O Type II O	cancer O	seizures O	lupus O	multiple sclerosis O	pulmonary disease O
osteoarthritis O	rheumatoid arthritis O	Fibromyalgia O	neuropathy O	Parkinson's O	stroke O	fracture O	concussion/ head injury O

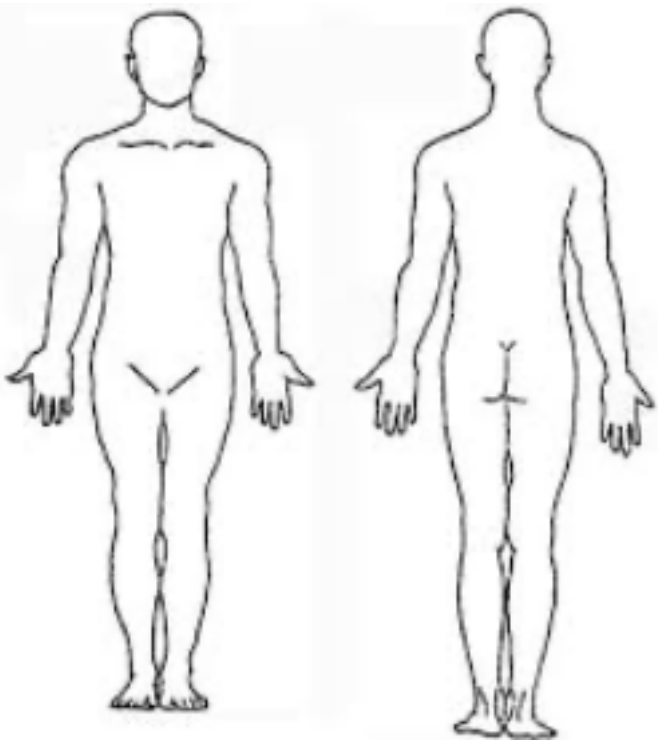
PLEASE LIST ALL PAST SURGERIES:

_____

_____

PLEASE LIST ALL MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY



Circle which number best describes your pain level: Mark above where your pain is located:

OVER THE PAST MONTH HAVE YOU BEEN EXPERIENCING? (check all that apply)

O fever, chills, night sweats	O fatigue	O numbness/tingling	O heartburn/ indigestion	O headaches
O changes in bowel/bladder	O weight loss	O weakness	O chest pain	O pain at night
O nausea/ vomiting	O loss of balance/falls	O dizziness/ lightheadedness	O shortness of breath	O throbbing pulse in your abdomen

During the past month have you been feeling down, depressed or hopeless: Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Would you like help? Yes Yes , but not today No

Policies & Procedures

Thank you for choosing Globerman Physical Therapy as your provider. The following are statements of our Financial and Office Policies which we require you to read and sign prior to seeing a therapist.

INSURANCE COVERAGE NOTICE: Our office verifies insurance coverage as a courtesy to our patients. We are not responsible for any misinformation or changes in your policy that result in your financial responsibility being greater than what we quote you. It is the responsibility of all patients to understand their coverage, benefits, and for the timely payment of their account. **If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit payment(s) to us**. If formal collection procedures become necessary, you will be responsible for any additional cost.

CANCELLATION AND NO SHOW POLICY NOTICE: Continuity of care is an important aspect of physical therapy. Frequent cancellations or failing to show for appointments impacts the effectiveness of your treatment as well as other patient's timely access to care. We request at least **24 hours' notice** if you are unable to make your appointment. If you are more than 15 minutes late, you may have to reschedule. If possible, we will try our best to see you that day. ****Cancellations within 24 hours of appointment AND No Shows are SUBJECT TO A $40 FEE**. After 2 No Shows your care will be discontinued.**

NOTICE OF PRIVACY PRACTICES: I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical therapist certifications.

CONSENT TO THERAPY: Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. The purpose of physical therapy is to treat ailments by creating a specialized treatment program that will ensure a safe and lasting recovery. All procedures will be thoroughly explained to you before you are asked to perform them. I understand and am informed that as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and to have any questions answered about my condition prior to or during treatment. It is your right to decline any part of your treatment at any time should you feel any discomfort, pain, or have other unresolved concerns.

I have read the above policy & procedures form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties. ***I acknowledge that I have read & fully understand the above general consent form. Any questions I had have also been answered to my satisfaction.***

_____

Signature of Patient (or Parent/Guardian) Date

_____

Witness (Signature of Globerman Physical Therapy Staff) Date