



2814 Camino Dos Rios Suite 406, Newbury Park, CA 91320 T: 805 375 1461 F: 805 498 7613 U: [www.nppt.com](http://www.nppt.com)

## INSTRUCTIONS

1. Accurately type your information in the “patient information” form. You can press “Tab” to go forward from box to box or “Shift + Tab” to move back a box.
2. When you are finished entering all of your information, please save the document to your computer.
3. Print out and sign and initial where the lines are highlighted.
4. Bring the printed document to the clinic for your first appointment

What you will need for your appointment:

1. Appropriate clothing allowing access to the area to be treated - for example shorts, loose fitting sweat pants, t-shirt or tank top (you may be doing exercise, especially after your initial evaluation).
2. The attached paperwork.
3. Current prescription from your doctor.
4. Microsoft Office Word 2003.lnk Insurance card.

Please be sure to get a copy **of all** your appointments when you come in. If you have any questions or concerns please feel free to call our office (805)375-1461.



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### PATIENT INFORMATION

PATIENT NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBERS: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

SSN# \_\_\_\_\_ SEX \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

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EMPLOYER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP \_\_\_\_\_

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REFERRING DR: \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

DATE/ONSET OF INJURY/CONDITION: \_\_\_\_\_ ACCIDENT \_\_\_\_\_ AUTO \_\_\_\_\_ WORK \_\_\_\_\_

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PRIMARY INSURANCE CO. NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

RELATION TO INSURED: Spouse \_\_\_\_\_ Child \_\_\_\_\_ Self \_\_\_\_\_

SECONDARY INSURANCE CO. NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

RELATION TO INSURED: Spouse \_\_\_\_\_ Child \_\_\_\_\_ Self \_\_\_\_\_

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HAVE YOU HAD ANY PHYSICAL THERAPY TREATMENTS THIS CALENDAR YEAR? YES \_\_\_\_\_ NO \_\_\_\_\_

HAVE YOU HAD OR ARE YOU CURRENTLY HAVING HOME HEALTH CARE? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHEN WERE YOU DISCHARGED? \_\_\_\_\_



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**MEDICAL INFORMATION**

<b>**DETAILED DESCRIPTION OF INJURY OR CONDITION**</b>

\*\*Have you had previous therapy for present condition for which you request treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state where \_\_\_\_\_ when \_\_\_\_\_

Do you now have/or have you had any of the following:

- |                     |                    |                                  |                    |
|---------------------|--------------------|----------------------------------|--------------------|
| Diabetes            | Yes _____ No _____ | Allergies to heat/ice            | Yes _____ No _____ |
| High Blood Pressure | Yes _____ No _____ | Pregnant (now)                   | Yes _____ No _____ |
| Heart Disease       | Yes _____ No _____ | Other Allergies                  | Yes _____ No _____ |
| Heart Attack        | Yes _____ No _____ | Previous Surgery                 | Yes _____ No _____ |
| Pacemaker           | Yes _____ No _____ | Hernia (Ventral, Inguinal, etc.) | Yes _____ No _____ |
| Headaches           | Yes _____ No _____ | Seizures                         | Yes _____ No _____ |
| Kidney Problems     | Yes _____ No _____ | Metal Implants                   | Yes _____ No _____ |
| Malignancies        | Yes _____ No _____ | Nervous Disorders                | Yes _____ No _____ |

If yes on any above, please explain and give approx. dates \_\_\_\_\_

Are you presently taking medication? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please list medications and for what condition:  
\_\_\_\_\_

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

I authorize Newbury Park Physical Therapy Center to furnish the insurance company with full information regarding treatment rendered, when so requested.

I authorize my insurance company to pay directly to Newbury Park Physical Therapy Center medical benefits otherwise payable to me and I will be responsible to Newbury Park Physical Therapy Center for all expenses incidental to treatment rendered not paid under this plan.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Newbury Park Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent in writing at any time.

PATIENT \_\_\_\_\_ WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

PARENT OR GUARDIAN, if patient is a minor \_\_\_\_\_



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## **OUR FINANCIAL POLICY**

Please initial following each statement to authorize.

**We may accept assignment of insurance benefits, however we need your initials after the following statements to acknowledge that you understand and accept these terms:**

Insurance is a contract between the patient or guarantor and the insurance company and Newbury Park Physical Therapy only bills insurance as a courtesy to the patient. I am financially responsible to Newbury Park Physical Therapy for services rendered. \_\_\_\_\_

I fully understand that Newbury Park Physical Therapy may not accept my insurance fees as payment in full. This would lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance. \_\_\_\_\_

I understand that it is my responsibility to obtain all necessary referrals from my doctor or Primary Care Physician as required by my insurance company. Prescriptions must be kept current from month to month. In the event that services are rendered and later denied by my insurance company(s) for lack of referral/pre-authorization, I understand it will be my responsibility to pay Newbury Park Physical Therapy for services rendered. \_\_\_\_\_

Unless appointments are canceled at least 24 hours in advance, our policy is to charge \$40.00 for missed appointments. This charge is not covered by insurance and is your responsibility to pay. \_\_\_\_\_

### **Assignment of Benefits**

I have read the Financial Policy. I understand and agree to this policy. I hereby authorize my insurance company to pay all benefits directly to:

Newbury Park Physical Therapy  
2814 Camino Dos Rios  
Suite #406  
Newbury Park, CA 91320

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian, if patient is a minor



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## PATIENT CONSENT TO TREAT

Please initial following each statement to authorize.

I authorize Newbury Park Physical Therapy Center to render appropriate treatment to me. I understand appropriate personnel will provide this treatment and that I have the right to refuse.

I authorize Newbury Park Physical Therapy Center to obtain or provide emergency care if conditions warrant it during a treatment session and I am unable to give consent (CPR or emergency care).

Patient Signature

Signature of guardian (minor) \_\_\_\_\_ Date \_\_\_\_\_

### **A patient has the right to:**

1. Be informed of the nature of their condition, the proposed treatment and alternatives, and the expected results/risks of the proposed treatment to the best of their knowledge.
  2. Be fully informed about the care and treatment to be furnished and participate in the planning and changing of care and treatment. This includes refusal of all or part of the proposed treatment after being informed of expected consequences of an activity.
  3. Voice grievances regarding care and treatment that is or is not furnished.
  3. Be informed of any experimental treatment and not receive such treatment unless the patient gives documented voluntary informed consent.
  
  4. Newbury Park Physical Therapy Center has the right to expect the patient to:
  5. Provide complete and accurate medical history and other necessary information in a timely fashion. This includes necessary billing information.
  6. Read and ask questions about all forms and documents that are requested to be signed.
  7. Participate in the development and review of the plan of treatment.
  8. Adhere to the treatment plan developed by the physical therapist including home exercises.
  9. Take an active role in identifying specific activities necessary for care.
  10. Be present and on time for scheduled appointments.
- Report undo stress and discomfort that may be elicited during' a treatment in a timely fashion.