NEWBURY PARK
PHYSICAL THERAPY

2814 Camino Dos Rios, Suite 406
Newbury Park, CA 91320
T: 805.375.1461
F: 805.498.7613
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. 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 DEMOGRAPHICS

Last Name:_____ First Name: _____ MI: _____

Social Security:_____ Gender: _____ Date of Birth: _____ Age: _____

Marital Status:_____ Student/Employment Status: _____

Address:_____ City:_____ State: _____ Zip: _____

Email Address:_____ Would you like appointment reminders by email? ☐Y ☐N

Home Phone:_____ Primary: ☐Y ☐N Work Phone: _____ Primary: ☐Y ☐N

Cell Phone:_____ Primary: ☐Y ☐N Would you like appointment reminders by text message? ☐Y ☐N

Would you like to receive statements by email? ☐Y ☐N

Spouse Name:_____ Phone Number:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Responsible Party _____ Phone:_____

How did you hear about Newbury Park Physical Therapy? _____

Date / Onset of Injury / Condition: _____

Have you received IN/OUT Patient Physical Therapy or any other Therapy services this calendar year?: ☐Y ☐N

If yes, describe services? _____

Have you received any Chiropractic Care this calendar year?: ☐Y ☐N If yes, number of visits: _____

Medicare Patients *Have you received Home Health Care this calendar year?*
This includes PT, OT, ST, home health aide or nursing care ☐Y ☐N

If yes, what is the name of the home health agency? _____

If yes, what is the Discharge date? _____ *(Please supply copy of discharge report)*

INSURANCE INFORMATION

Primary Insurance:_____ Policy Holder Name: _____

Relationship to Policy Holder:_____ Policy Holder DOB: _____

Secondary Insurance:_____ Policy Holder Name: _____

Relationship to Policy Holder:_____ Policy Holder DOB: _____

MEDICAL HISTORY

Allergies	☐YES	☐NO	Dizzy Spells	☐YES	☐NO	MRSA	☐YES	☐NO
Anemia	☐YES	☐NO	Emphysema/Bronchitis	☐YES	☐NO	Multiple Sclerosis	☐YES	☐NO
Anxiety	☐YES	☐NO	Fibromyalgia	☐YES	☐NO	Muscular Disease	☐YES	☐NO
Arthritis	☐YES	☐NO	Fractures	☐YES	☐NO	Osteoporosis	☐YES	☐NO
Asthma	☐YES	☐NO	Gallbladder Problems	☐YES	☐NO	Parkinson's	☐YES	☐NO
Autoimmune Disorder	☐YES	☐NO	Headaches	☐YES	☐NO	Rheumatoid Arthritis	☐YES	☐NO
Cancer	☐YES	☐NO	Hearing Impairment	☐YES	☐NO	Seizures	☐YES	☐NO
Cardiac Conditions	☐YES	☐NO	Hepatitis	☐YES	☐NO	Smoking	☐YES	☐NO
Cardiac Pacemaker	☐YES	☐NO	High/Low Blood Pressure	☐YES	☐NO	Speech Problems	☐YES	☐NO
Chemical Dependency	☐YES	☐NO	High Cholesterol	☐YES	☐NO	Strokes	☐YES	☐NO
Circulation Problems	☐YES	☐NO	HIV/AIDS	☐YES	☐NO	Thyroid Disease	☐YES	☐NO
COVID-19	☐YES	☐NO	Incontinence	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Currently Pregnant	☐YES	☐NO	Kidney Problems	☐YES	☐NO	Vaccination COVID-19	☐YES	☐NO
Depression	☐YES	☐NO	Metal Implants	☐YES	☐NO	Vision Problems	☐YES	☐NO
Diabetes	☐YES	☐NO						

Describe any other conditions or precautions: _____

_____

FALL HISTORY

Is this injury a result of a fall in the past year? ☐Y ☐N Date of fall: _____

Have you had two or more falls in the last year? ☐Y ☐N Date of falls: _____

SURGICAL HISTORY

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

CURRENT MEDICATIONS

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

CURRENT SYMPTOMS

Currently, I am experiencing (check all that apply):		☐ Fever/chills/sweats	☐ Poor balance (falls)
☐ Unexplained Weight Loss	☐ Numbness or Tingling	☐ Change in appetite	☐ Difficulty swallowing
☐ Depression	☐ Shortness of Breath	☐ Dizziness	☐ Headaches
☐ Changes in bowel or bladder function		☐ Nausea/vomiting	☐ Increased pain at night

☐ Y ☐ N	During the past month, have you often been bothered by feeling down, depressed or hopeless?
☐ Y ☐ N	During the past month, have you often been bothered by little interest or pleasure in doing things?

Is this something with which you would like help?

☐ Yes - today ☐ Yes - but not today ☐ No - I do not want help

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

Patient Signature: _____ Witness: _____ Date: _____

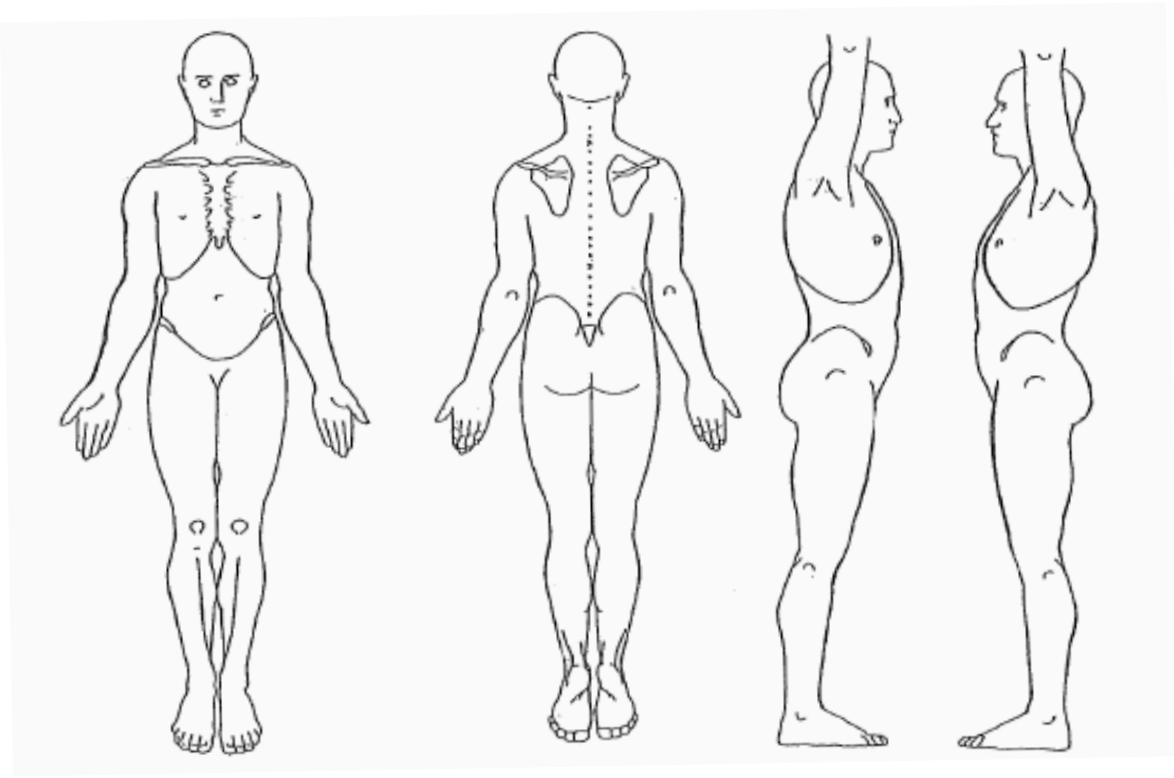
Parent/Guardian (If patient is a minor): _____ Date: _____

PT Initials: _____

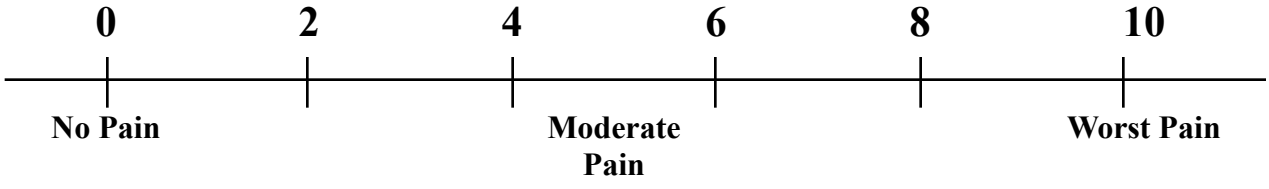
Office Use Only

NEWBURY PARK
PHYSICAL THERAPY

PAIN LOCATION
BODY CHART



PAIN INTENSITY SCALE



- Please mark a number on the pain intensity scale that best describes your pain at the present time.
- Draw the location of you pain on the body chart above
- If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

Please describe the details of your injury, including the date of injury and any treatment on the injury:

Name:_____ **Date:**_____

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OUR FINANCIAL POLICY

Please initial following each statement to authorize.

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. _____

Newbury Park Physical Therapy accepts payment in the form of cash, check, or charge. If I pay via credit card, Newbury Park Physical Therapy can keep my card on file unless told otherwise. This card will be used for all applicable co-pays, co-insurance, and deductible payments. _____

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. 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 **$90.00** for missed appointments. This charge is not covered by insurance and is my 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
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Suite #406
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Patient Signature: _____ Date: _____

Parent or Guardian, if patient is a minor: _____

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PATIENT CONSENT TO TREAT

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). _____

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.
4. Be informed of any experimental treatment and not receive such treatment.

NEWBURY PARK PHYSICAL THERAPY HAS THE RIGHT TO EXPECT THE PATIENT TO:

1. Provide complete and accurate medical history and other necessary information in a timely fashion. This includes necessary billing information.
2. Read and ask questions about all forms and documents that are requested to be signed.
3. Participate in the development and review of the plan of treatment.
4. Adhere to the treatment plan developed by the physical therapist including home exercises.
5. Take an active role in identifying specific activities necessary for care.
6. Be present and on time for scheduled appointments.
7. Report undue stress and discomfort that may be elicited during a treatment in a timely fashion.

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand Newbury Park Physical Therapy's Notice of Information Practices. I understand that Newbury Park Physical Therapy may use my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to payment or treatment. I have been given an opportunity to obtain a copy of Newbury Park Physical Therapy's Notice of Privacy Practices should I ask for it. _____

Patient Signature: _____ Date: _____

Parent or Guardian, if patient is a minor: _____