G3 PHYSICAL THERAPY & WELLNESS CENTER

***Please complete the information below. If you have any questions, please ask a Front Desk Associate for assistance.*

PATIENT INFORMATION	Today's Date: _____ Would you like reminder calls? ❑ Yes ❑ No What's your favorite treat? _____

Last name:	First:	Middle:

Home phone number:	Cell phone number:

Street address:	Birth date:	Age:	Sex: ❑ M ❑ F	Height:	Weight:

City:	State	Zip Code:

Occupation:	Employer phone number:

Email Address:	Would you like to receive emails regarding physical therapy/fitness/wellness? ❑ Yes ❑ No

How did you hear about us?

INSURANCE INFORMATION	
PLEASE FILL OUT IF YOU **ARE NOT** THE PRIMARY CARD HOLDER	
Insurance Card Holder Birth date:	Address (if different than above):
Patient's relationship to card holder?	Phone number:

DOCTOR'S INFORMATION	
Referring Physician/Family Doctor:	Phone Number:

EMERGENCY CONTACT		
Name:		
Relationship to patient:	Home/Cell phone number:	Work phone number:

PHYSICAL THERAPY & WELLNESS CENTER

Patient Name: _____

Injury/Surgery:	**Date of onset OR Date of surgery:**
Any relevant info regarding the reason you're being seen today:	

Have you ever experienced any of the following conditions?

	YES	NO		YES	NO		YES	NO
Anemia/Blood Disorder			Falls			Lung Disorder		
Arthritis			Gynecologic Conditions			Neurological Disorder		
Bowel/Bladder Problems			Headaches (>1 per week)			Osteoarthritis		
Cancer			Hearing Problems			Osteoporosis		
Depression			Hernia			Rheumatologic Disorder		
Diabetes			Kidney Problems			Thyroid Condition		
Dizziness			Liver/ Kidney Condition			Vision Problem		
CARDIOVASCULAR	**YES**	**NO**		**YES**	**NO**	**HOSPITALIZATIONS**	**DATE**	
Arterial Blockage of Legs			Head Trauma					
Deep Venous Thrombosis			Fractures					
Heart Disease			Seizures					
High Blood Pressure			Sensitivity to Ice					
Stroke			Sensitivity to Heat					

	PLEASE LIST ALL MEDICATIONS	**FREQUENCY AND DOSAGE**
1.		
2.		
3.		
4.		

HEALTH RELATED ISSUES (Please circle the answer that applies)

Do you smoke? Yes No	Alcohol consumption: daily weekly occasionally rarely never	
Please list any allergies you have:		
Are you pregnant? Yes No	Have you experienced recent unplanned weight loss? Yes No	
Do you have asthma? Yes No	Do you wear a pacemaker? Yes No	Metal implants? Yes No

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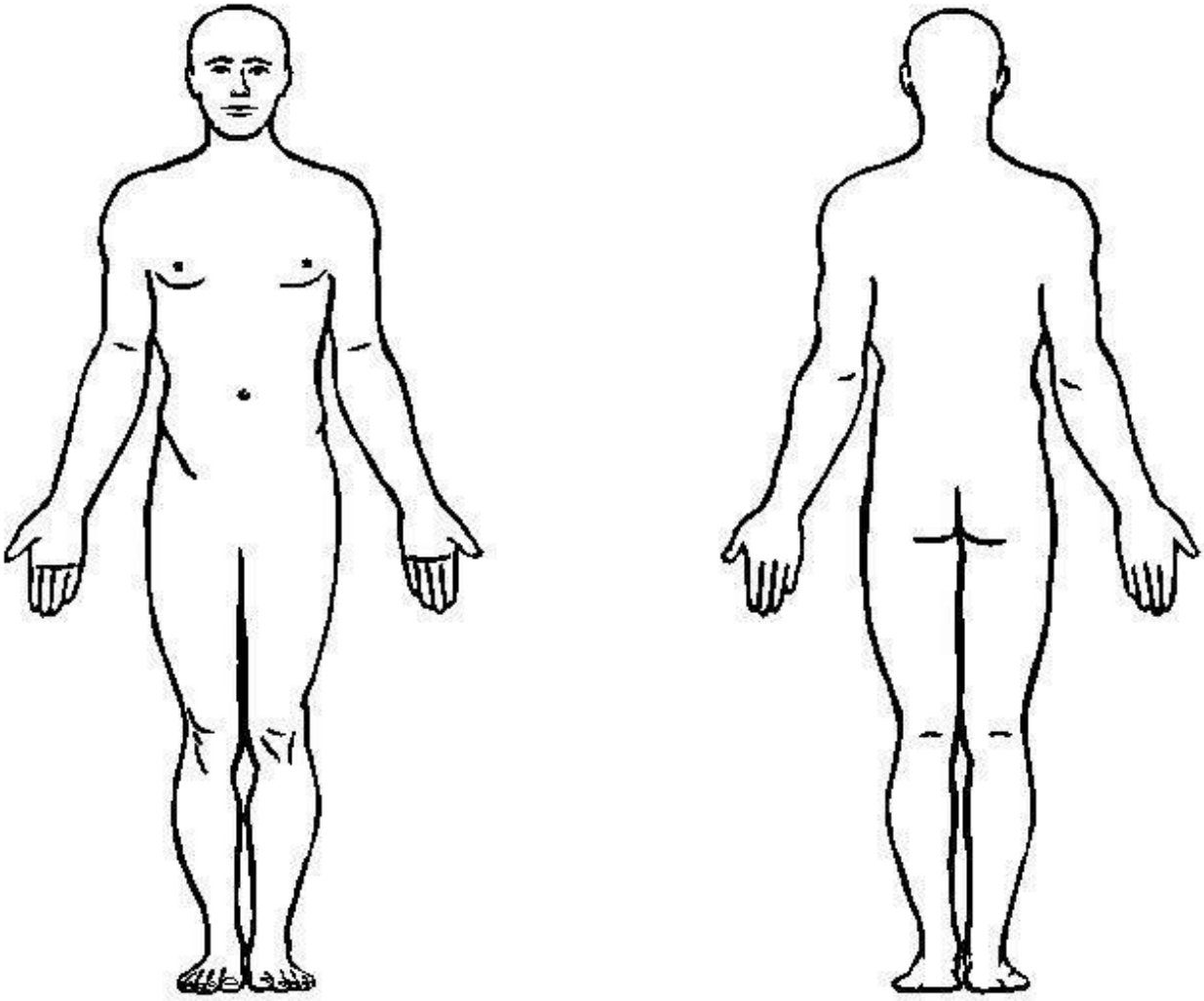
Patient Name: _____

Circle the area of discomfort on the body chart below:



Rate the intensity of your pain at its BEST: 0 1 2 3 4 5 6 7 8 9 10
Rate the intensity of your pain at its WORST: 0 1 2 3 4 5 6 7 8 9 10
Which word best describes the quality of your discomfort? (check all that apply) ❑Aching ❑Stabbing ❑Numbness ❑Dull ❑Burning ❑Pins & Needles

Credit Card Authorization Form

CREDIT CARD ON FILE POLICY

At G3 Physical Therapy & Wellness Center, we require keeping your credit or debit card on record (in a secure tokenized format) as a convenient method of payment for the ESTIMATED co-pay/co-insurance portion of services that your insurance doesn't cover, but for which you are liable.

Deductibles and Co-Pays

All Patient Responsibility Deductibles and Co-Pays are due in full at the time of service.

Additionally, once claims have been processed by your insurance company, if you have a balance on your account, you can call us to approve payment over the phone for the exact amount your insurance company states is your responsibility, with your card on file. A receipt will be provided for any charges processed by *G3 Physical Therapy and Wellness Center* if requested.

❑ **Visa** ❑ **Mastercard** ❑ **Discover** ❑ **American Express**

Name on Card _____

Account# *Please present card to Front Desk Staff Member* **Expiration** _____ **Security** _____

Billing Address _____

I have read the above, and I agree to the terms and conditions. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of G3 Physical Therapy and Wellness Center. ***I agree to assign all health insurance benefits directly to G3 Physical Therapy and Wellness Center and understand that I am responsible for any costs not covered by my health insurance. I also understand and agree that my credit card can and will be used for the cost for Cancellations and No-Show fee's.***

Patient Signature _____ **Date** _____

Notice of Patient Information Practices

*****PLEASE RETAIN THIS COPY FOR YOUR RECORDS*****

**Please ask a Front Desk Associate if you have any difficulties understanding the following information*

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review carefully.

G3 Physical Therapy and Wellness Center's Legal Duty

G3 Physical Therapy and Wellness Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

G3 Physical Therapy and Wellness Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

G3 Physical Therapy and Wellness Center may also use or disclose your health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

G3 Physical Therapy and Wellness Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam area and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. G3 Physical Therapy and Wellness Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact:

Michael Van Gilder PT, DPT, Privacy Officer (760) 452-2640
G3 Physical Therapy and Wellness Center
227 N. El Camino Real Suite #100 Encinitas, CA 92024 / 740 Lomas Santa Fe, Suite #208, Solana Beach, CA 92075

**Please ask a Front Desk Associate if you have any difficulties understanding the following information*

Please initial that you have read each statement and sign at the bottom of this page.

Cancellation and No-Show Policy

24- Hour Cancellation Policy:

_____If you need to cancel a Physical Therapy appointment, please give us 24 hours' notice so we have the opportunity to offer your appointment to another patient. If less than 24 hours' notice is given, you will be charged a $25 cancellation fee.

No Show Policy:

_____If you do not show up for a scheduled appointment, you will be charged a $30 no-show fee.

Patient Information Consent

_____I have read and fully understand *G3 Physical Therapy and Wellness Center's* Notice of Information Practices. I understand that *G3 Physical Therapy and Wellness Center* may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal information is used and disclosed for treatment, payment, and administrative operations, if I notify the practice. I also understand that *G3 Physical Therapy and Wellness Center* will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.

_____I hereby consent to the use and disclosure of my personal health information for purposes as noted in the G3 Physical Therapy and Wellness Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Direct Physical Therapy Treatment Services Disclosure Statement

_____You are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT/PTA) licensed by the Physical Therapy Board of California.

_____Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of CA, or by the Osteopathic Medical Board of CA, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon podiatrist.

The information I have provided on this paperwork is true to the best of my knowledge. I consent to treatment for physical therapy. I authorize my insurance benefits to be paid directly to G3 Physical Therapy and Wellness Center. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize G3 Physical Therapy and Wellness Center to release any information required to process my claims and secure the payment of benefits. I am fully aware of the policies set forth by G3 Physical Therapy and Wellness Center, and I agree to abide by the policies as outlined in this paperwork.

Print Patient Name: _____

Patient / Guardian Signature: _____

Date: _____

Authorization to Take and Use Photographs/Video and Waiver and Release of Claims

Please check the appropriate boxes to either opt in or opt out of consent to use your image in G3 media and marketing materials:

❑ I opt in ❑ I opt out

If opting in, please complete the following:

I_____hereby grant G3 Physical Therapy (G3PT), its directors, officers, employees, agents, and designees (collectively "G3PT) non-revocable permission to capture my image and likeness in photographs, videotapes, motion pictures, recordings, or any other media (collectively "Images"). I acknowledge that G3PT will own such Images and further grant the G3PT permission to copyright, display, publish, distribute, use, modify, print and reprint such Images in any manner whatsoever related to G3PT business, including without limitation, publications, advertisements, brochures, web site images, or other electronic displays and transmissions thereof. I further waive any right to inspect or approve the use of the Image by G3PT prior to its use. I forever release and hold G3PT harmless from any and all liability arising out of the use of the Images in any manner or media whatsoever, and waive any and all claims and causes of action relating to use of the Images, including without limitation, claims for invasion of privacy rights or publicity.

Printed Name _____

Signature _____

**IF PATIENT IS A MINOR, PLEASE PRINT AND SIGN BELOW:

I hereby certify that I am the parent and/or guardian of a child under the age of 18 years, and I hereby consent that any Images (as defined above) may be used for any purposes set forth in the Authorization and Release above.

Parent or Guardian Printed Name _____

Parent of Guardian Signature _____