ProFizix Physical Therapy & Wellness

3392 Motor Ave. LosAngeles. 90034
Tel: (310) 742-2230; (844) 440-0801 Fax: (310) 659-4626

Patient Information

Patient's Name: _____ Nick Name/Preferred Name:_____

Social Security Number:_____-___-_____

Date of Birth: _____/_____/_____ Age_____ Gender: _____

Marital Status: Single___ Married___ Divorced___ Widowed___

Mailing Address: _____ Apt/Unit#:_____

City: _____ State:_____ ZipCode:_____

Home Phone: _____ Cell Phone:_____Work Phone:_____

Email: _____

Employer:_____

Employer Address/Phone:_____

Additional Information:

Primary Care Physician: _____Referring Physician:_____

How Did you Hear About Us: _____

Would like to receive our newsletters and other related physical therapy information?_____

Optional Questions:

Preferred Language:_____

Race:_____Ethnicity:_____

Responsible Party:

Same as Patient Information *(If different, please complete section below)*

Self/ Parent/Guardian: _____ Name: _____

Address: _____Phone: _____

Emergency Contact:

I authorize ProFizix Physical Therapy and Wellness to release health information to my Emergency Contact : Yes___Initial: _____

Name: _____

Relationship: _____

Phone: Home/Cell/Work:_____

Address: _____

Insurance Information:

Primary Insurance Company: _____

Address:_____ _____ Phone:_____

Relation to Subscriber: _____

Policy/ ID #: _____ Group #:_____

Subscriber Name: _____ Birth Date: _____/_____/_____

Secondary Insurance Company: _____

Address:_____ Phone:_____

Relation to Subscriber: _____

Policy/ ID #: _____Group #: _____

Subscriber Name: _____ Birth Date: _____/_____/_____

MEDICAREPATIENTS: are you currently enrolled in Home Health? Yes_____ No____
If YES: (List Company Name):_____

WORKERS COMPENSATION / AUTO ACCIDENT:

If you want us to bill for WorkersComp or an auto accident,we will do so.We Ask that present us with your private health insurance information as backup. I realize that if my workers comp or auto benefits should be denied or exhausted that I would be responsible for any charges incurred.

PleaseSign:_____Date:_____

Patient Consent:

Welcome to **ProFizix Physical Therapy and Wellness**. We are delighted to have you onboard. It is our goal to provide each patient with the best possible care throughout the course of therapy. Please review our office policies below, and feel free to discuss any questions you might have with us.

CONSENT FOR CARE & TREATMENT

1. I hereby authorize **ProFizix Physical Therapy and Wellness** to administer such medical examination diagnostic procedures and/or treatment that, in their judgment, may indicate to be advisable for the patients well being. I certify that no guarantee or assurance has been made as to the result that may be obtained.
   Initial Here:_____

2. I realize I have the right to refuse any drugs,treatments or procedures to the extent permitted by law. 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.
   Initial Here:_____

WORKERS COMPENSATION

3. I hereby authorize my rehab consultant to receive my records related to my work injury.
   Initial Here:_____
4. Employers/school representatives have the right to verify dates on work/school. Initial Here:_____

ASSIGNMENT OF INSURANCE BENEFITS

5. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I authorize payment of my insurance benefits to be made directly to **ProFIzix Physical Therapy and Wellness**. I agree to pay in full any and all charges not paid by insurance or other benefits.
   Initial Here:_____

FINANCIAL POLICY

6 **.** I am responsible for co-payments, deductibles , and any services not covered by this authorization. I agree to pay the amount due to **ProFizix Physical Therapy and Wellness** within thirty (30) days of billing date, and agree to pay any late charges and collection fees as appropriate. I have read and FULLY UNDERSTAND the PATIENT FINANCIAL RESPONSIBILITY FORM.
   Initial Here:_____

CANCELLATION, NO-SHOW & LATE ARRIVAL

7. I understand that if I do not attend therapy for **two 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 California State Law.*
   Initial Here:_____
8. I understand that if I am unable to keep my appointment, I must give **1 day notice** to **ProFIzix Physical Therapy and Wellness** or a **$35.00** cancellation charge will be assessed.
   Initial here:_____

M.D. REFERRAL/PRESCRIPTION

9. Unless you qualify for direct access, Please understand that we need a current prescription (Rx) from your physician in order to bill your insurance company. In the event that your insurance does not pay for services rendered, you will be responsible for outstanding balances and/or obtaining a back dated Rx. It is your responsibility to obtain your current M.D. referrals/prescriptions as needed during the course of your treatment. Medicare requires a new referral every 30 days from the last date seen by your physician.

Initial here:_____

Signature of Patient (or Guardian/Parents of a Minor–under18*)* _____

Date: _____

Consent For Minor:

1. I, being the parent/guardian entitled to care, custody, and control of the aforesaid minor, do hereby authorize and direct you to render such treatment to say minor in your judgment. It is understood that the above minor may occasionally appear at your clinic for examination or treatment, or both, unaccompanied by an adult, because of my (our) absence or unavailability.
   Initial here:_____

2. I understand that the physicians, nurses or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purpose of assisting in the diagnosis or treatment. I agree to cooperate by being present with said minor whenever possible, especially when my presence is specifically requested.
   Initial here:_____

3. This consent will be in effect until it is terminated by written notice received by **ProFIzix Physical Therapy and Wellness** where the original has been filed.
   Initial here:_____

Signature of Guardian/Parents of a Minor–under18*)* _____

Date: _____