



**WELCOME TO COAST**  
Physical Therapy Specialists

Dear Patient:

**WELCOME** to COAST Physical Therapy Specialists. For many of you, this will be your first contact with the Physical Therapy profession. In brief, our therapists are educated and trained professionals who treat physical dysfunction's and provide orthopedic rehabilitation. Our staff is committed to work with you to achieve your goals and to help you return to a fully productive and independent lifestyle.

Your physician has recommended and referred you to physical therapy for a specific problem. Based upon this referral, our therapists will perform an evaluation, develop a treatment plan and manage your injury or disease. We will continually re-evaluate your progress and regularly report your progress to your physician. In order for the Therapist to report your progress to the Physician, it is imperative to attend the program as outlined. Missing sessions could adversely affect the rehabilitation process, lessening the positive effects of the program and possibly prolong your return to normal activities.

Physical Therapy is for your benefit. Therefore, it is important that you take an active role in the rehabilitation process so that you will obtain the maximum benefit from your program. During your program, you may be asked to perform certain activities at home. It is very important that you carefully follow the instructions given and perform the activities, as they will assure you of a quicker recovery. It is also important that you feel free to communicate both positive and/or adverse reactions to activities done either in the clinic or those you are doing at home. This information will assist the therapist in modifying your program so that the maximum benefit will occur. You will find that we are quite open-minded about your individual problem and very much will listen to what you have to say and feel. If you find it necessary to cancel an appointment, please be kind enough to give us a 24-hour notice and attempt to talk to your therapist so that he/she can determine whether any modification of your program should take place.

We truly look forward to helping you achieve your goals and hope that you will enjoy an improved quality of life!

Kindest Regards,

THE ENTIRE STAFF  
COAST PHYSICAL THERAPY SPECIALISTS

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**Patient Signature**

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**Date**

**NEW PATIENT INFORMATION SHEET**

Patient Name; (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Appointment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Appointment Time: \_\_\_\_\_ Account #: \_\_\_\_\_

**PERSONAL INFORMATION**

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M or F  
Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Employer: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**INSURANCE INFORMATION**

Insurance Name: \_\_\_\_\_ ID/Policy #: \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Claim Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Claim FAX #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Plan associated with IPA: Y or N IPA Name: \_\_\_\_\_  
Secondary Insurance Name: \_\_\_\_\_  
Secondary Ins. Policy #: \_\_\_\_\_ Verification Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PAYOR INFORMATION**

Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Home Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M or F  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INJURY INFORMATION**

Have you had previous surgery for this injury? Yes or No Date of Injury/accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Injury Type: Work / Auto / Other (accident/injury due to other than Auto or work) or None (not an accident)  
Injury Details (Body Part): \_\_\_\_\_

(If accident – include where and how it occurred / if non-accident, include reason for visit)

**State** where accident occurred: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Referring Physician Name: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Physician Address: \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ NPI: \_\_\_\_\_  
Prescription Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ # of Visits ordered: \_\_\_\_\_ Special Instructions: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Therapist: \_\_\_\_\_ Therapist's Code: \_\_\_\_\_

**Patient Signature** (certifying that all personal information above is correct)

**Date**

**CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for COAST Physical Therapy Specialists to furnish medical care and treatment considered necessary and proper in diagnosing or treating (Patient) \_\_\_\_\_'s physical and/or mental condition.

**Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

**PATIENT'S NAME:** \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **INSURANCE COMPANY:** \_\_\_\_\_

- I hereby instruct and direct my Insurance Company to issue checks made out and mailed directly to :COAST PHYSICAL THERAPY SPECIALISTS (1701 Solar Drive, Ste 155, Oxnard, CA 93030) for the professional and/or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** A photocopy of this assignment shall be considered as effective and valid as the original.
- I hereby authorize said assignee to release all information necessary to my Insurance Company, Adjustor, Doctor's office, or Attorney involved in my case.
- **MY CONDITION IS NOT A WORKER'S COMPENSATION CASE OR PART OF A LIEN (Unless otherwise noted)** \_\_\_\_\_ (Patient's Initials)

I authorize COAST Physical Therapy Specialists to furnish information to my insurance carrier(s) concerning my treatment, and I hereby assign all payment for services rendered. I agree to pay any outstanding balances after my insurance carrier has paid its portion of the bill.

**Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FINANCIAL POLICY STATEMENT**

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that payment of your estimated share be made on the date of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made to COAST, you will be responsible for the full amount of money refunded to your insurance company. In the event that your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining. **If your insurance makes any payments directly to you for services rendered by us, you recognize an obligation to promptly submit the payment to COAST Physical Therapy Specialists.** I understand and agree that if I fail to make the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

**I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

**Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTIFICATION OF PATIENT RESPONSIBILITY FOR CO-PAYMENTS/CO-PERCENTAGES AND DEDUCTIBLES**

Your company requires Coast Physical Therapy Specialists to collect your co-payments or co-percentages and any unmet deductible amounts from you at the time of service. If we do not collect these amounts, we could be in direct violation of our contract with your insurance company and could be at risk being denied reimbursement for your treatment.

COAST has verified your physical therapy benefits based on the information given by you. **Your insurance company writes the disclaimer that this is a verification of benefits and not a guarantee of payment.** Based on the information your insurance company provided us with, your benefits are as follows:

**Co-Payment:** \_\_\_\_\_ /visit    **Co-Percentage:** \_\_\_\_\_ /visit    **Estimated amount:** \_\_\_\_\_ /visit  
**Deductible:** \_\_\_\_\_    **Amount not met:** \_\_\_\_\_    **Maximum visits allowed:** \_\_\_\_\_ /year

**PLEASE NOTE:** *If you have already paid your deductible to another provider but our claims are received first by the insurance company, the deductible will be applied to our claim and you will owe the balance to COAST. You will then need to obtain a refund from the provider that originally collected your deductible from you.*

**ESTIMATED** coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. The estimate is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company. Reimbursement of services are based on your specific insurance plan, and any discrepancies are strictly between you and your insurance carrier. Please do not hesitate to contact us regarding your billing concerns.

**I HAVE READ THIS FORM ENTIRELY AND UNDERSTAND MY FINANCIAL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. I AGREE TO REMIT PAYMENT AS AGREED ON THE DATE OF SERVICE.**

**Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NO SHOW / APPOINTMENT CANCELLATION POLICY**

- Please provide our office with at least a 24-hour notice to change or cancel an appointment. We have an answering machine that you are more than welcome to use for after hours and on the weekends.
- We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hours notice allows us to place another patient in your cancelled appointment period to receive needed treatment.
- **If 3 or more appointments are missed consecutively at any time during a patient's rehabilitation, any further appointments you may have already scheduled may be taken off the schedule.** The patient will then be required to schedule their appointment each day they plan on attending therapy, provided an opening is available.
- **A charge will be applied for "No-Show" or "Non 24-Hour" cancellations.** Please avoid the inconvenience and give us the courtesy of a phone call at least 24-hours in advance.

**Patient/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Medical History

### Existing or Relevant Previous Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High/Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

Describe any other conditions:

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

### Fall History

- Injury as a result of a fall in the past year? Height: \_\_\_\_\_
- Two or more falls in the last year? Weight: \_\_\_\_\_

### Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

### Current Medications

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

- Currently not taking any medications