Name: (Dr. /Mr. /Mrs. /Ms.)___________________________________ Date: ______/______/_____
Address: ____
City: __________________ State: ________ Zip: ____________________
Home Phone: ___________________________ Work Phone: __________________________
Social Security Number: _______-______-_______ Date of Birth: ______/______/_______
Emergency Contact: ____
Referring Physician: ____
Are you currently receiving any home health services? (i.e. nursing, therapy, lab tests) ___Yes ___ No
Party Responsible for Payment: ___ Self ___ Workers' Compensation ___ No-Fault ___ Attorney (provide name)
____

If Work-Related, please provide the following information:

Employer: ____

Occupation: ____

Address: ____

Currently Working: __ Yes __ No

Insurance Provider: ____

Group #:____________________ ID #: _______________________________________

Secondary Insurance: ____

Group #:____________________ ID #: _______________________________________

Reason for visit? Area of pain issue? ____

What are your primary complaints? (circle all that apply)

Pain; Weakness; Stiffness; Numbness; Spasm; Decreased Motion; Swelling; Poor Balance; Walking; Other:
____

Describe what you were doing at the time of your injury:
____

Rate your pain intensity:

2300 Westwood Blvd #100, Los Angeles, CA 90064
Office: (424) 365-2083 Fax: (310) 943-3532

Medications:____
(Mandatory for Medicare patients)

Have you received any treatment, including surgery for this condition? ___ NO ___ YES (if yes, please list below)

____

Medical & Surgical History: (List any relevant information below):

____

____

____

CONSENT TO TREATMENT: I consent to rehabilitation and related services from Jason Ferine MSPT and JFPT. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

*Initials:*___________________

TREATMENT OF MINORS: The patient, if at least eighteen (18) years old, or married and if physical and mental condition permits. I, as parent/ guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. A consent form must be signed by the patient, legal guardian or authorized person responsible for the patient. The consent form includes permission to treat in accordance with the physician's orders and release of information to third-party payers.

*Initials:*___________________

LIABILITY: I know and agree that Jason Ferine MSPT and JFPT are not responsible for loss or damage to personal valuables.

*Initials:*___________________

WAIVER AND RELEASE: I hereby release, discharge and acquit Jason Ferine MSPT and JFPT, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

*Initials:*___________________

CANCELLATION POLICY: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. It is our policy to reschedule any cancelled appointments for the same week at the time of your call. There is a $25 charge for a cancellation without a 24 hour notice. Attending your scheduled appointments is crucial to successful treatment and recovery from your injury.

*Initials:*___________________

PRIVATE INSURANCE HOLDERS: We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company.

We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment. Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim.

*Initials:*_________________

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Jason Ferine MSPT and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand that if I do not provide the correct information required for billing, I may be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, legal/court costs. I hereby give permission to Jason Ferine MSPT to perform the evaluation requested and to release all necessary medical information to parties responsible for payment. I understand that I have the right to terminate any or all parts of the evaluation at any time and I am responsible for notifying the evaluator of any and all changes in my symptoms as they occur. We accept CASH, MASTERCARD, VISA, DISCOVER, AMEX, and PERSONAL CHECKS.

*Guardian / Witness Signature:*____

Signature: ______________________________ *Date:* ______________________________