145 Vista Avenue Suite #103
Pasadena, CA 91107
(626) 365-1380
healthfitinc.com

New Patient Information Forms

Full Name

Preferred Pronouns

Preferred Name

Date of Birth

Age

Marital Status
○ Single ○ Married ○ Separated ○ Divorced

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Daytime Phone #

Cell Phone #

Email

Emergency Contact Name

Relationship

Phone #

Primary Care Physician

Specialty

Other Doctors You See

Specialty

Upload Valid Photo ID

How did you learn about our practice or whom may we thank for referring you?

List your major concern(s), in order of importance to you.

	Concern	Slight	Moderate	Severe
1				
2				
3				

Additional:

Level of pain of complaint:

0 - Not difficult / 10 - Unbearable

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Pains are:

☐ Sharp ☐ Dull/Ache ☐ Constant

☐ Intermittent ☐ No Pain

Does this pain shoot, radiate, or travel in your body?

○ Yes ○ No

If yes, where?

Are you experiencing numbness or tingling?

○ Yes ○ No

If yes, where?

What activities aggravate your condition/pain?

What activities lessen your condition/pain?

Is this condition worse during certain times of the day?

Is this condition interfering with:

☐ Work ☐ Sleep ☐ Routine

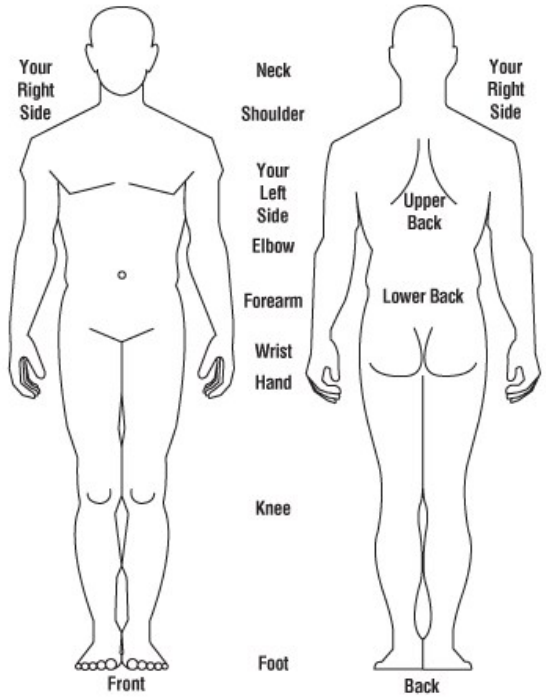
☐ Other ☐ It doesn't interfere with anything

Additional details

Would you be interested in other services our facility provides? If so, check all that apply

- ☐ Hyperbaric Oxygen Therapy Chamber (HBOT)
- ☐ Red Light ☐ Custom Pillows ☐ Custom Orthotics
- ☐ Postural Gear ☐ Supplements

Please indicate areas of concern:



MEDICAL HISTORY

Please list any conditions that you have or have had. (i.e. Cancer, Diabetes, Stroke, Heart Attack, etc.) Please include date of diagnosis.

	Condition	Date Diagnosed	Date Subsided
1			
2			
3			

HEALTH HABITS & OCCUPATIONAL CONCERNS

Please check all that apply. Include the amount consumed. Comment if necessary.

- ☐ Alcohol
- ☐ Sugar
- ☐ Tobacco
- ☐ Artificial Sweeteners
- ☐ Excessive Computer
- ☐ Caffeine
- ☐ Drugs

- ☐ Stress
- ☐ Repetitive Motion
- Use/Typing
- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Other

If other, please explain:

MEDICATIONS AND SUPPLEMENTS

Please list all the prescription medications and supplements that you are currently taking, as well as the duration and dosage. Please bring your medications and supplements with you to the first office visit.

	Name	Purpose	Duration & Dosage
1			
2			
3			
4			
5			

Please mark any of the following conditions or symptoms that you are currently experiencing.

- ☐ Headaches
- ☐ Numbness in Hands/Arms
- ☐ Pain in Legs/Feet
- ☐ Low Back Pain
- ☐ TMJ
- ☐ Dizziness
- ☐ Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Stroke
- ☐ Menopause
- ☐ Painful Urination
- ☐ Blood Clots
- ☐ Asthma
- ☐ Seizures
- ☐ Dental Issues
- ☐ Neck Pain
- ☐ Numbness in Legs/Feet
- ☐ Shoulder Pain
- ☐ Abdominal Pain
- ☐ Ringing in Ears
- ☐ Irritability
- ☐ Lights Bother Eyes
- ☐ Sleeping Problems
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Stomach Problems
- ☐ Circulatory Disorder
- ☐ Joint Disorder
- ☐ Allergies
- ☐ Sinus Problems
- ☐ Other
- ☐ Neck Stiffness
- ☐ Pain in Hands/Arms
- ☐ Chest Pains
- ☐ Carpal Tunnel
- ☐ Tension
- ☐ Loss of Memory
- ☐ Nervousness
- ☐ Respiratory Disorder
- ☐ Heart Attack
- ☐ Weight Loss
- ☐ Constipation/Diarrhea
- ☐ Contagious Disease
- ☐ Muscle Injury
- ☐ Arthritis
- ☐ Skin Problems

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I, _____, hereby give my consent to treatment at HealthFit, Pasadena; and any employee working under the direction of the physicians to provide care and/or render services that are necessary for my care. Treatment and service may include but are not limited to preventative diagnostics, therapeutic, rehabilitation, maintenance, palliative, counseling, assessment, and the sales or dispensing of medical devices, therapeutic equipment and nutritional supplements required and in accordance with my treatment plan or prescription.

I also understand that there may be risk involved in any diagnostic/treatment/physical activity and that there are other treatment options available. I hereby consent to care and release HealthFit, and its agents from any liability, now and I the future, for possible injury.

To administer any relevant treatment, therapy, training for my care.

Consent for release of information and assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice.

Direct Physical Therapy Treatment Services Disclosure

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) 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 California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice pediatric medicine from the California Board of Pediatric Medicine and acting within his/her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient and evaluation was conducted by the physician and surgeon or podiatrist.

With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

I have read, understand and agreed to the above consent and service disclosure policies and statements and accept full responsibility as stated above.

_____ _____

*To be signed by parent/legal guardian if patient is under 18 years of age.

_____ _____

Patient or Guardian Signature Date

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Protected Health Information Consent Form

With my consent, **HealthFit Physical Therapy and Chiropractic** may use and disclose protected health information (PHI) to carry out treatments, payments, and healthcare options (TPO).

I have the right to review the HealthFit Consent Forms prior to signing this document. **HealthFit** reserves the right to revise its consent forms rights at any time. A revised HealthFit Consent Form may be obtained by forwarding a written request to **HealthFit**.

With my consent, **HealthFit** may call my home, or other designated locations, to leave messages on voicemail or in person, in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to physical therapy and/or chiropractic care.

With my consent, **HealthFit** may send mail to my home, or other designated locations, any items that assist the practice in carrying out TPO, such as appointment reminder cards and/or patient statements.

By signing this form I am consenting to **HealthFit's** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient Full Name	Patient Signature	Date

Authorized Representative's Full Name	Authorized Representative's Signature	Date

Client Signature	Date

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Patient Financial Responsibility

Thank you for choosing HealthFit for your health care needs. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial responsibility and appointment cancellation/rescheduling policies, which are as follows:

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at court, any settlement, structured settlement, verdict or arbitration award which may be received or be due, or the course of outcome of any dispute regarding the same.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).
- The patient is responsible for any costs associated with the collection of patient balances.
- The office charges a $30 fee for returned checks.
- **It is our policy to collect payment in full for Physical Therapy & Chiropractic service on the date rendered.**
- Packages expire 12 months after date of purchase and are **nonrefundable/nontransferable**.

- For Physical Therapy and Chiropractic Services: The patient (Under the age of 65 with PPO Insurance) will be provided a Superbill for self-submittal for potential reimbursement upon request.

No-Show/Late Cancellation Policy

Our office sets aside a specific amount of time for you and your doctor exclusively to incorporate personal 1-on-1 treatment sessions.

We will make every attempt to confirm your scheduled appointment with you 24 hours in advance via text and/or email alerts.

If you will be unable to make it to your set appointment, we kindly request for **AT LEAST** a 24-hour notice of cancellation or request for rescheduling. This allows us to offer the appointment slot to another patient on our waiting list. In the event of a late cancellation, late reschedule or no-show, a fee will be applied accordingly. Please see the following:

- **LESS** than a 24-hours notice of cancellation will result in a charge equal to **50%** of the scheduled service total cost.
- "No-Show" appointments that are missed without any given notice will be charged in **FULL**.
- Appointments made within the 24-hour period that need to cancel/reschedule, must be done so with **AT LEAST** 4-hours notice of scheduled appointment time or will result in a charge of **50%** of the scheduled service amount.

HealthFit reserves the right to settle cancellation/rescheduling fees, co-pays, deductibles, and any outstanding balances due with the patient's payment information on file.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form and Appointment Cancellation/Rescheduling Policy:

_____ _____

*To be signed by parent/legal guardian if patient is under 18 years of age.

_____ _____

Patient Signature Date

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HealthFit COVID-19 Safety Compliance Policy

HealthFit is taking all precautions to protect you and everyone here at the office. The following questions should be reviewed prior to EACH appointment in order to screen for health safety:

1. Have you had a fever or felt feverish in the last 72 hours?
2. Are you experiencing any respiratory symptoms, including a runny nose, sore throat, cough or shortness of breath?
3. Are you experiencing any new muscle aches or chills?
4. Have you experienced any new changes in your sense of taste or smell?
5. Does anyone in your household have any of the above symptoms?

I understand that I will be subject to the above screening questions prior to beginning each appointment. It is my responsibility to answer each question truthfully and to the best of my knowledge.

In the event that I answer YES to any of the above questions, I agree to notify the staff immediately.

_____

If you have been exposed to COVID-19 OR are experiencing any COVID-like symptoms OR test positive, we ask that you please wait to come in for:

- 5 days since exposure or since symptoms first appeared or since positive test, AND at least 24 hours with no fever (without fever reducing medication) AND other symptoms are improving

If you have been exposed to COVID-19 and are not experiencing symptoms, we ask that you wait:

- 5 days since exposure AND no symptoms reported during 5 day period, with a negative result from a COVID-19 test taken on Day 5

COVID-19 Vaccine Policy

The above policies apply, regardless of being unvaccinated or vaccinated.

I understand that HealthFit policies are subject to change as CDC guidelines update.

_____

_____ _____

Client Signature Date