LONGEVITY
physical therapy

Whom may we thank for referring you?	Today's Date:
❑ Doctor _____ ❑ Family Member _____ ❑ Friend _____ ❑ Website _____ ❑ Other _____	

PATIENT INFORMATION

Last Name: First: Middle:

Home Phone Number:	Cell Phone Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	Zip Code:		
Email Address:				
Occupation:	Employer:	Employer Phone Number: ( )		

DOCTOR'S INFORMATION

Referring Physician/Family Doctor:

Phone Number:	

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Home Phone Number:	Cell or Work Phone Number:

The above information 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 Longevity Physical Therapy. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize Longevity Physical Therapy to release any information required to process my claims and secure the payment of benefits.

Patient/Guardian Signature *Date*

LONGEVITY physical therapy

Injury/Surgery:	Date of Onset/ Date of Surgery:

Previous Treatment:

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		PLEASE LIST ALL MEDICATIONS
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

I affirm the above information accurate to the best of my knowledge.

Patient/Guardian Signature *Date*

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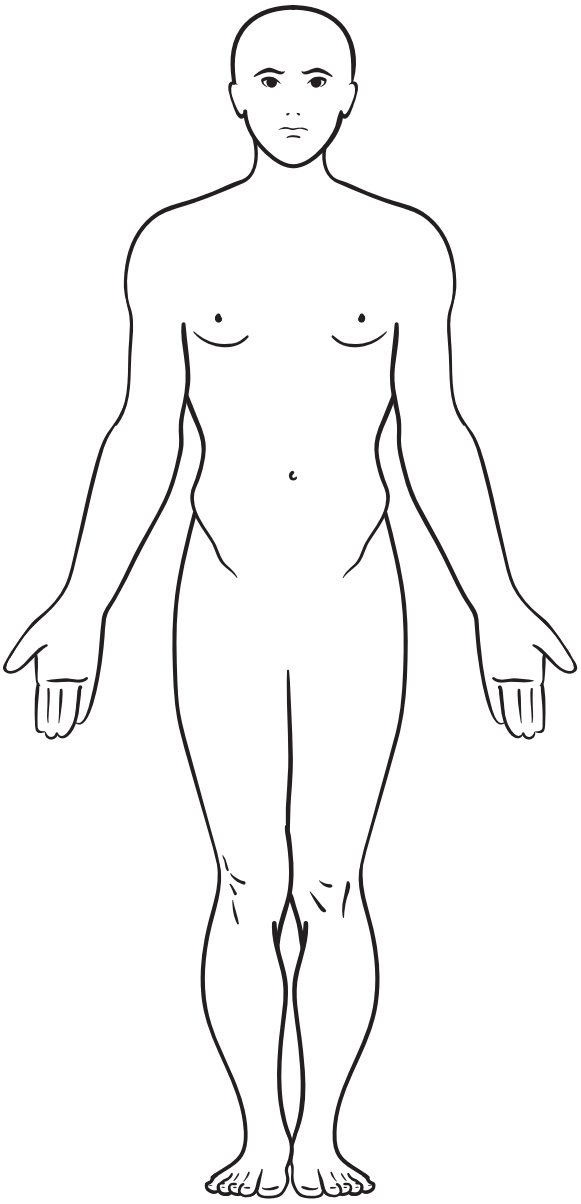
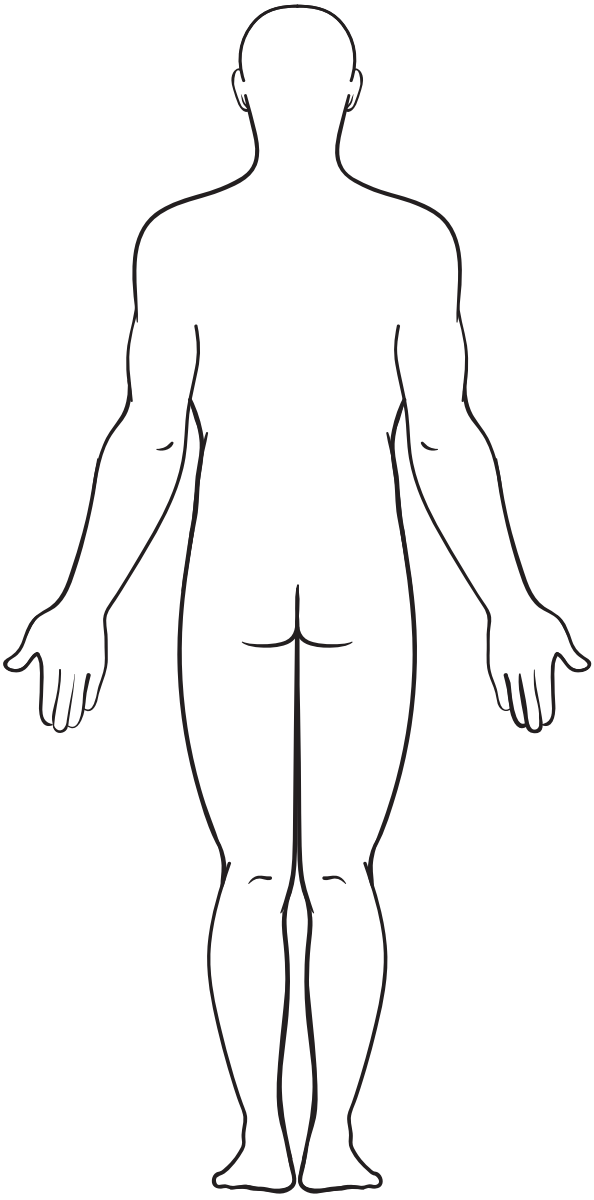
physical therapy





Rate the intensity of pain. Circle the appropriate number:

0=None 5=Moderate 10=Extreme

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Which word best describes the quality of your discomfort?

Aching	Stabbing
Numbness	Dull
Burning	Pins and Needles

INFORMED CONSENT AGREEMENT

As a new patient of Longevity Physical Therapy I hereby acknowledge and understand the following:

Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services (collectively "Therapy"):The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. Physical therapists are not authorized in California to diagnose disease.

Longevity Physical Therapy does not discriminate and Therapy being provided by Longevity Physical Therapy are provided without regard to the patient's race, religion, gender, color, national origin, ancestry, physical handicap, sexual orientation, medical condition, marital status, age or sex. Response to Therapy treatment varies by individual. Therefore, it cannot and Longevity has not, predicted my response to Therapy. While the goal is for improvement of the condition in which I am seeking Therapy, I understand that there is a possibility that my condition may worsen and Therapy may cause pain, injury, exposure to Covid-19, and even death. I also understand and acknowledge that I may develop new or different injuries as a result of my participation in a physical therapy program and in receiving Therapy. I ACKNOWLEDGE THAT I AM KNOWINGLY AND VOLUNTARILY PARTICIPATING IN PHYSICAL THERAPY AND RECEIVING PHYSICAL THERAPY WITH AN EXPRESS UNDERSTANDING OF THE DANGER INVOLVED AND HEREBY AGREE TO ACCEPT AND ASSUME ANY AND ALL RISKS OF INJURY, DEATH, OR DAMAGE, WHETHER CAUSED BY THE ORDINARY NEGLIGENCE OF LONGEVITY OR OTHERWISE.

With full knowledge of the above, I hereby knowingly and voluntarily assume any risks associated with the Therapy that I receive and I, along with my heirs and assigns, fully and forever release Longevity, its owners, partners and providers of Therapy services from any and all injury which may naturally occur and which are inherent in receiving Therapy.
I understand that it is my right to decline to participate in physical therapy in general and specifically to any treatment proposed by Longevity Physical Therapy and that I will immediately notify my physical therapist of any pain, discomfort, dizziness, or any other concern that I may have. I understand that it is my right to ask the physical therapist about my specific treatment plan along with the associated risks and benefits.I further acknowledge that I have consulted with my physician prior to participating in Therapy to determine whether Therapy is safe, warranted and recommended and I have been informed that it is. I further acknowledge that I have been advised that I need to fully disclose any medical condition that I have that may affect my Therapy and that if I am not sure then to discuss such condition with my physical therapist prior to receiving Therapy.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTOOD ALL OF THE TERMS OF THIS CONSENT, UNDERSTAND THE RISKS ASSOCIATED WITH PHYSICAL THERAPY, AND THAT I AM VOLUNTARILY PARTICIPATING IN PHYSICAL THERAPY. I AM VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE LONGEVITY FOR CLAIMS, WHICH MAY NATURALLY OCCUR AND WHICH ARE INHERENT IN RECEIVING THERAPY.

I have read, acknowledged, adopted, understood and have agreed to be bound by the above.

Patient Name _____ Signature_____ Date_____

If Minor (under 18): Parent or Legal Guardian Name and Signature: _____

LONGEVITY PHYSICAL THERAPY

Patient Information Consent

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

I have read and fully understand Longevity Physical Therapy's Notice of Information Practices. I understand that Longevity Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, any administrative operations related to treatment or payment, emergencies, research studies, auditing purposes, public health/statistical purposes and when required by law. I. 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 Longevity Physical Therapy 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 Longevity Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Patient Name _____

Signature_____ Date _____

Signature of Guardian (if patient a minor) _____

PATIENT TREATMENT AGREEMENT

Cancellation and No Show Policy. I understand that if I cancel my scheduled appointment with less than 24 hours' notice a $50 cancellation fee will be assessed to me. I understand that if I fail to show up for a scheduled appointment without a call, a $75 no-show fee will be assessed to me.

I understand that Longevity Physical Therapy will keep my credit card information on file for the purpose of charging the cancellation fee and I hereby authorize Longevity to charge my credit card in the event that such a charge is necessary.

I understand that I need to verify my Physical Therapy Benefits directly with my health plan, including, but not limited to deductibles, co-pays, number of visits allowed, prescription/pre-authorization required. I agree that I ultimately am financially responsible for the treatment provided to me in the event that my insurance carrier does not cover the full cost of my treatment. You will be provided a copy of your insurance verification form which details the benefits that Longevity Physical Therapy confirmed for you on the date of your evaluation.

I understand and agree that Function for Life Physical Therapy DBA Longevity Physical Therapy shall not be liable for the loss or theft of, or damage to my personal property, including my vehicle and I hereby release in advance any such claims that I may have in further consideration of being treated at Longevity Physical Therapy.

I represent that I am physically able to safely participate in physical therapy and I have received clearance from my physician to undergo physical therapy.

I hereby agree and consent that I may be photographed or videotaped while receiving physical therapy for purposes of advertising and/or social media. I UNDERSTAND THAT I DO NOT NEED TO CONSENT TO BEING PHOTOGRAPHED OR VIDEOTAPED FOR PURPOSES OF AVERTISING AND/OR SOCIAL MEDIA AND THAT I AM VOLUNTARILY PROVIDING CONSENT TO BE PHOTOGRAPHED OR VIDEOTAPED. I FURTHER UNDERSTAND THAT I CAN REVOKE SUCH CONSENT AT ANY TIME AND THAT I HAVE READ AND UNDERSTAND LONGEVITY'S NOTICE OF PATIENT INFORMATION PRACTICES.
Sign here to opt out: _____

I agree that I have read, understand and agree to the terms listed above and that I have been advised to seek legal counsel regarding any of the above.

Patient Name _____

Signature_____ Date _____

CREDIT CARD AUTHORIZATION FORM

Deductibles and Co-Pays

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

As a courtesy to you, we allow you to secure your account and your appointments with a credit card. We can charge your card the estimated patient responsibility for each visit based on the quote from your insurance company at the beginning of your treatment. Additionally , we can use your credit card on file to make a charge for the exact amount your insurance company states is your responsibility once your claims have been processed and you have a balance on your account. A receipt will be provided for any charges processed by Function For Life Physical Therapy if requested.

I understand that Longevity Physical Therapy will keep my credit card information on file for the purpose of charging the cancellation fee and I hereby authorize Longevity to charge my credit card in the event that such a charge is necessary. (initial)

Please initial

_____ I choose to have my credit card on file for the estimated amount due at each visit. My credit card on file will also be used for any remaining balance once payments have been received from my insurance company.

_____ Visa _____ Master Card ____ Discover ____ AmEx

Name on Card_____

Credit Card Number (last four digits only) _____ Expiration _____

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 Longevity Physical Therapy. I agree to assign all health insurance benefits directly to Longevity Physical Therapy 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 _____

****Our official corporate name is Function For Life Physical Therapy, Inc.**
Thus, this official name may appear on your billing/credit card statement.

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LONGEVITY PHYSICAL THERAPY

Notice of Patient Information Practices

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

Longevity Physical Therapy's Legal Duty
Longevity Physical Therapy 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
Longevity Physical Therapy 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.

Longevity Physical Therapy 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.

Longevity Physical Therapy 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. Longevity Physical Therapy 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:

Brett Bloom, Owner (760) 918-9200
Longevity Physical Therapy 2719 Loker Avenue W, Suite A Carlsbad, CA 92010

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