MATRIX
Physical Therapy & Wellness

Patient Information Sheet

Legal Full Name_____ **Date**_____

Preferred Name_____ **Date of birth**_____ **Age**_____

Social Security Number_____ **Referring Doctor name:** _____

If patient is a minor, please give name and address of person legally responsible:
Name_____Phone_____
Address_____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Woman/Transwoman ☐ Transgender Man/Transman
☐ Additional Identities:_____ ☐ Decline to state

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Decline to state

Pronouns: ☐ she/her ☐ he/him ☐ they/their ☐ Other:_____

Home Address_____City_____Zip_____

Home phone number_____Mobile phone number_____

Driver's License Number_____Email_____

Occupation_____Employer_____

Name of Spouse/Partner_____Spouse's phone number_____

How did you get to us (check all that apply)? ☐ Doctor_____ ☐ Internet Search
☐ Yelp ☐ Referral from friend/family _____ ☐ Health Insurance Website
☐ Other_____ Were you referred to a specific therapist (name)_____

Please provide our office with a copy of your primary and secondary insurance along with a copy of your photo ID. We submit claims to insurance companies as a courtesy to our patients, but it is ultimately the patient's responsibility to verify benefits with their insurance company.

Date of injury or when your symptoms began_____Is condition work-related?_____
Is condition related to an automobile accident?_____Is there a lawsuit?_____
If so: Attorney_____Phone_____

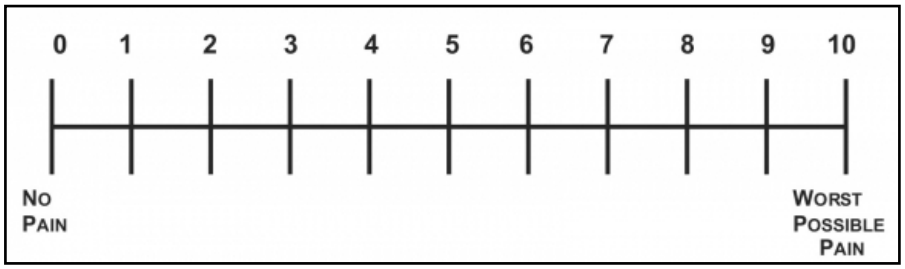
Emergency Contact: please provide information of relative / close friend:
Name_____Phone_____
Address_____

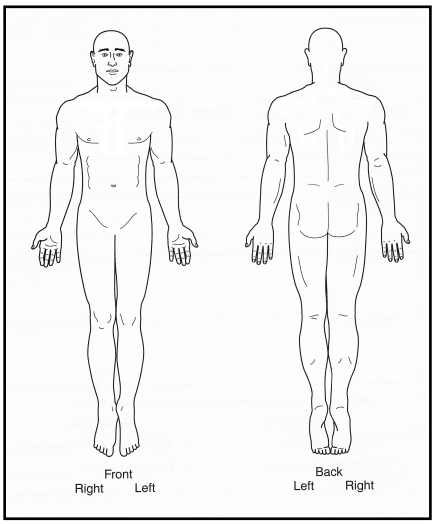
Have you had Home Health services of ANY KIND (physical therapy, occupational therapy, nursing, etc.)? ____Yes ____No. If YES, were you officially discharged by your home health provider? ___Yes ___No. If No, or you're not sure, please inform the front desk since Medicare will not cover your outpatient visits until you are officially discharged from home health services. Failure to inform us could result in you being financially responsible for visits not covered.

Patient name: _____

Patient History

If you have pain, please place a vertical line on the scale below to indicate the level of your pain at its worst:





On the above body diagram, indicate where you have your current symptoms.

Please indicate if you had/have any of the following:

	Yes	No	If Yes, please explain (include dates/treatment):
Cancer / Tumor	___	___	_____
High Blood Pressure	___	___	_____
Heart or Circulation Disorder	___	___	_____
Stroke	___	___	_____
Surgical Implant / Hardware	___	___	_____
Diabetes	___	___	_____
Neurological disorder	___	___	_____
Dizziness	___	___	_____
Pacemaker	___	___	_____
Arthritis	___	___	_____
Osteopenia / Osteoporosis	___	___	_____
Immune Deficiency	___	___	_____
Autoimmune disorder	___	___	_____
Head Trauma / Head aches	___	___	_____
Other Orthopedic injuries/surgeries	___	___	_____
Abdominal pain	___	___	_____
Other_____	___	___	_____

Do you currently or have you previously smoked cigarettes? ___Yes ___No If yes, please describe the frequency of smoking (i.e. packs per day, # of years smoking, etc.):_____If you have quit smoking, when did you quit?_____

Please list results of recent diagnostic studies (X-rays, MRIs, CT scans, PET scans, bone density, blood work, etc.):

_____

Have you had an unusual weight loss recently? ___Yes ___No. Hand Dominance: Right___ Left___ Ambidextrous___

List medications you are taking and start date:_____

Are you pregnant: ____Yes ____No If yes, for how long have you been pregnant?:_____

Have you had physical therapy, occupational therapy or chiropractor treatments this year?
___Yes ___No If yes, please indicate when and how many: _____

Do you have a history of trauma or other personal considerations that you would like your PT to be aware of? _____

_____

Date of next appointment with referring physician: _____

Specific Activity / Sport participation: _____

Matrix Physical Therapy and Wellness, PC
Patient Information Consent

I have read and fully understand Matrix Physical Therapy and Wellness, PC's Notice of Privacy Practices. I understand that Matrix Physical Therapy and Wellness, PC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Matrix Physical Therapy and Wellness, PC 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 Matrix Physical Therapy and Wellness's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____	_____	_____
Patient Name	Signature	Date

Consent to Treatment

Therapy at Matrix Physical Therapy and Wellness, PC (Matrix PT) is a patient care service that is provided in order to manage a wide variety of conditions/diseases. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, sexual identity, or disability.

The purpose of therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to therapy intervention varies from person to person; therefore, it is not possible to accurately predict your response to a specific modality, procedure, or exercise program. Matrix PT does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your therapist about the treatment they have planned based on your individual history, therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

It is difficult to anticipate the cost to you for our therapy services due to variations in insurance company co-pays / co-insurance and deductible amounts. Our out-of-pocket therapy fees are $225.00 for an initial evaluation and $175 for follow-up visits.

If you receive physical therapy services without having seen a physician, the following section applies to you:

Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist 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 podiatric medicine from the California Board of Podiatric Medicine and acting within his or 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 examination and evaluation was conducted by the physician and surgeon or podiatrist.

I have read this consent form and understand the risks involved in therapy and agree to fully cooperate, participate in all therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name_____ Signature_____ Date_____

Financial Policy

Thank you for choosing Matrix Physical Therapy and Wellness, PC as your health care provider. The following is our financial policy. Please read and sign the statement prior to initiating any treatment.

1. All patients must complete the information sheet.
2. **Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payments, co-insurance, visit limitations, and any pre-authorization requirements.** As a courtesy, we will also verify your coverage but will not guarantee the accuracy of the information we receive from representatives and/or online portals. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are ultimately responsible for knowledge of insurance benefits and for the full payment of your bill.
3. Co-payments or co-insurance payments are due each visit.
4. **All patients must have a credit card on file. If payment is due, the credit card on file will be charged automatically. These payments can include health insurance copays/coinsurance, health insurance deductible payments, and/or $60 no-show fees or $60 late-cancel fees (less than 24 hours notice). If charges can not be made on date of service, they will be processed as soon as possible.**
5. If you do not have insurance, full payment is due at the time of service.
6. We accept cash, checks, and most credit cards.
7. If you fail to pay a bill that is more than 30 days past due, you will not be able to continue scheduling visits.

We bill insurance companies as a courtesy to our patients. However, you are ultimately responsible for all co-payments, co-insurance or any part of the bill not paid by your insurance company.

In order for us to bill an insurance company, patients must provide us with the following:

1. A copy of your insurance card.
2. Personal information filled out completely on our intake paperwork.

Please be advised that this office will require payment in full for treatments rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is also your responsibility to check with your insurance company regarding the status of your claim.

Depending on your insurance plan, you might be required to pay co-payment or co-insurance for services rendered. This can be a fixed dollar amount per visit (co-payment), or a percentage of the charge for the visit (co-insurance). Since we will not be able to ascertain the exact dollar amount of a co-insurance payment in advance, we will estimate that amount and collect it at each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check to you if over-payment is determined. Payment is expected within 15 days of the date of the statement. A finance charge of 1.5% will be assessed on all delinquent accounts.

I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including number of visits, deductible amount, requirement of pre-authorization (when indicated), and co-insurance or co-payment amounts.

A charge of $60.00 will be billed for any missed appointment without 24 hours notice.

Please let us know if we can help you with any of the above information.

By my signature below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to, any services or fees denied or not covered by my insurance company.

I certify that I have read and fully understand all of the above information.

_____ _____

Signature of patient or responsible party Date

Consent to Email Communications

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the use of email communications that might include protected patient health information. However, HIPAA-covered entities like us must apply reasonable safeguards when transmitting patient health information. This includes limiting the amount of information included in emails, verifying that the correct email address is being used, not using personal information in subject lines, and preventing unauthorized users from accessing information. We utilize a secure email service that encrypts emails, but we can not guarantee that servers and systems used on the receiving end are adequately protected. When we use email to communicate with patients, there will still be potential for unauthorized individuals to view your personal health information.

Communications can include appointment reminders, patient schedules, home exercise programs, and treatment-related information. Official medical records will only be sent via email with an explicit request from the patient in writing. Medical records sent to authorized third parties will not be sent via email. At anytime, a patient has the right to withdraw their consent to email communication.

By signing below, I authorize Matrix Physical Therapy and Wellness and it's associates to communicate with me via email. I certify that I have read and fully understand all of the above information.

_____ _____

Signature of patient or responsible party Date