PATIENT INFORMATION FORM

Last Name: ____ First: ______________________________________Middle Initial: ______

Preferred Name (If Different from Above) ____________________ Gender: MALE – FEMALE DOB: _________________Age: _______

*****IF Under the age of 19, Please Print Parent/Guardian Name:*** ____

Street/Mailing Address: ____ PO Box (If applicable): ____________________

City: ____State: ________________Zip: ______________________

Cell Phone: ____ Home phone: ____

*****EMAIL (Required):*** ____(Used for Clinic Purposes)

EMERGENCY CONTACT

Name: ____Relationship to Patient: ____________________________

Cell Phone: ____ Home Phone: ____

*****PRIMARY CARE PHYSICIAN:*** _____________________________________ *****REFERRING PHYSICIAN:*** ___________________________

APPOINTMENT REMINDERS

I authorize Fremont Therapy & Wellness to send me voicemail, text message and/or email reminders.
I understand that text-messaging rates may apply.

(Please Circle): Phone Reminders Text Reminders Email Reminders

LATE CANCEL / NO SHOW POLICY

Please call ***24+ Hours in Advance*** to cancel your appointment or a ***$35 LATE FEE*** will be applied to your account for each appointment you No Show or call to cancel the day of the appointment.
Rescheduled appointments within the same treatment week ***WILL NOT*** be charged the late fee.
Each patient will receive ***ONE FREE Cancellation/No Show*** (per Month) where the fee will be waived.
After cancelling 3 visits in less than 24 hours without rescheduling, our office will contact you regarding setting up future scheduling requirements. Cancellations and no-shows are documented in your medical record.

HOW DID YOU FIND US? *We LOVE to thank our referral sources.*

Web/Facebook: ________ Insurance/Work Comp: __________Past Patient: __________

Family/Friend (Please list): ____

Doctor (Please list): ____

Other Family Members Seen Here ____

PATIENT SIGNATURE: ____ ***DATE:*** ____________________

PARENT/GUARDIAN SIGNATURE: ____ ***DATE:*** ___________________

PATIENT CONSENT FORM

Last Name: ____ First: _________________________________DOB: _____ /_____ /_____

CONSENT TO TREAT
I consent to physical and/or occupational therapy evaluations and treatments that my therapist and I agree are necessary and part of my plan of care. I understand that no guarantee has been made as to the results of the care, treatment and/or medications given to me.

CONSENT TO TREAT DURING COVID-19
I consent to have therapy services at Fremont Therapy & Wellness during the COVID-19 pandemic. I have been provided with additional COVID-19 information and I consent to follow ALL guidelines of Fremont Therapy & Wellness.

CONSENT TO RELEASE MEDICAL/THERAPY RECORDS
I hereby authorize Fremont Therapy & Wellness to release my medical information & therapy records to my physicians, insurance carriers, Workman's Comp, etc. concerning this treatment and I hereby assign all payment for services rendered. I have provided Fremont Therapy & Wellness with up to date insurance information and I understand that it is my responsibility to inform them of any changes in insurance providers during my plan of care of treatment. I understand that if my claim(s) is/are denied, I may be held responsible for the total amount due to Fremont Therapy & Wellness for services rendered.

CONSENT FOR TELEHEALTH SERVICES
I acknowledge & agree that I have been provided details about the option of TeleHealth Therapy and agree to participate in this alternative method of therapy in order to keep me on track with my current plan of care. I understand that during the course of my TeleHealth sessions, my therapist may determine that TeleHealth services are not the most appropriate means for my therapy care and alternative methods may be needed to continue my therapy. I understand that I am able to WAIVE the option of TeleHealth Services by marking "Not Interested".

(Please Mark 1st Choice) - TeleHealth via – ZOOM: _____ Doxy.me: _____ FaceTime: _____ NOT INTERESTED_______***

HIPAA CONSENT
I acknowledge & agree that I have been provided the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct (**HIPAA**) information & the Notice of Privacy Practices. I hereby authorize the ***Designated Parties Below*** to request/receive any/all of my protected health information regarding my therapy treatments, accounts/payments and/or administrative operations related to my care. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If NONE, ***Please Circle***: *NONE*

Name: ____***Relationship:*** ___________________

Name: ____***Relationship:*** ___________________

Name: ____***Relationship:*** ___________________

SOCIAL MEDIA CONSENT I hereby authorize Fremont Therapy & Wellness to use my photo and/or general information for advertising/marketing purpose.
******I prefer that: My complete name be used________ My first name only be used________ No Name be used_________***

CONSENT TO TREAT A MINOR
The undersigned does hereby authorize Fremont Therapy & Wellness consent to exam and treat the above mentioned minor by employees of Fremont Therapy & Wellness without a Parent or Guardian present.
******Important additional Medical Information (Allergies, Medications, etc.)____***

I understand and accept ALL of the above policies regarding treatment at Fremont Therapy & Wellness and understand I can request a copy of this document for my own records.

PATIENT SIGNATURE: ____ ***DATE:*** ____________________

PARENT/GUARDIAN SIGNATURE: ____***DATE:***_____________________

PATIENT MEDICAL HISTORY FORM

Last Name: ____ First: ___________________________________DOB: _____ /_____ /____

Describe Accident/Injury/Issue____

Date of Accident/Injury/Issue ____Hospitalization Dates: ___________________________

Injury is related to: Work Related/Work Comp_______ Sports Injury_______ Car Accident_______ Other:_________________________

Have you fallen in the last year?_______ If Yes, How many times?_________ When was last fall? _______ Any Near Falls? ___________

PLEASE RATE YOUR PAIN TODAY ON A SCALE OF (NO PAIN) 0 - 10 (WORST IMMAGINABLE PAIN)______________________________

PLEASE DESCRIBE PAIN *(Please check ALL that apply)*

DULL_____ ACHE_____SHARP_____STABBING_____CONSTANT_____INTERMITTENT____GETTING WORSE_____GETTING BETTER_____

Past History: Please check if you have or ever had one of these conditions or problems

☐ Pacemaker	☐ Parkinson's	☐ Anxiety or Depression	☐ Headaches/Migraines
☐ Defibrillator	☐ Multiple Sclerosis	☐ Chemical Dependency	☐ Meniere's Disease
☐ Latex Allergy	☐ Stroke/CVA/TIA	☐ Weight/Energy Loss	☐ Balance Problems
☐ Diabetes	☐ Cancer/Chemo/Radiation	☐ Thyroid Disease	☐ Dizziness or Fainting
☐ Epilepsy/Seizures	☐ Fibromyalgia	☐ Rash (current)	☐ New Increased Weakness
☐ High Blood Pressure	☐ Rheumatoid Arthritis	☐ Allergies	☐ Peripheral Neuropathy
☐ Low Blood Pressure	☐ Lupus	☐ Use an Epi-Pen?	☐ Numbness/Tingling
☐ Coronary Artery Disease	☐ Infectious Diseases	☐ Are you Pregnant?	☐ Circulation Problems
☐ A-Fib	☐ MRSA	☐ Incontinence	☐ Hearing Difficulties
☐ Heart Attack or Surgery	☐ Tuberculosis	☐ Kidney Problems	☐ Changes in Vision
☐ High Cholesterol	☐ HIV/AIDS	☐ Bladder or Kidney Surgery	☐ Metal Implants/Pins
☐ History of blood clots	☐ Hepatitis	☐ Hysterectomy	☐ Hand/Wrist pain
☐ Emphysema/bronchitis	☐ Transplants	☐ C-Sections	☐ Neck/Arm pain
☐ Use an Inhaler	☐ Gallbladder Removal	☐ Spinal Injections	☐ Back/Leg pain
☐ Shortness of Breath	☐ Anemia	☐ Episiotomy	☐ Foot/ankle pain
☐ Osteoporosis	☐ Hernia	☐ On blood thinners	
☐ Do you Smoke	☐ Gout	☐ Back Pain at night	☐ I HAVE NONE OF THE ABOVE

☐ Chiropractor- Name:________________________________ ☐ Massage Therapist Name:______________________________

☐ Had any Recent X-Rays, MRI, CT Scans, or other tests? ____

☐ Joint Replacements (List type, side, year)____

☐ Orthopedic or Spinal Surgeries (Carpal Tunnel, Scopes, Fractures etc.)____

☐ Functional problems (stairs, out of chairs, walking outside)____

List any other relevant surgeries including date:____

MEDICATIONS – (WE CAN TAKE A COPY OF YOUR LIST IF YOU HAVE IT BUT PLEASE CHECK APPROPIATE BOXES)

Are you on any of the following types of prescription or non-prescription Medications (Check)

☐ I AM NOT TAKING ANY MEDICATIONS	☐ Nerve Medications (Ex: Neurontin, Gabapentin)
☐ Over the Counter Pain Medications (Tylenol)	☐ Diabetic Medications
☐ Over the Counter Anti-inflammatories (Ex: Ibuprofen, Aleve)	☐ Antibiotics
☐ Prescription Anti-inflammatory (Ex: Meloxicam, Celebrex, Voltaren)	☐ High Blood Pressure Medications
☐ Prescription Pain Medications (Ex: Oxycodone, Tramadol)	☐ Anti-Depressants
☐ Muscle Relaxants (Ex: Flexeril, Soma)	☐ Blood Thinners
☐ Cardiac Medications	☐ Others (For What):
☐ Vitamins (List):_______________________________________	

PATIENT SIGNATURE: ____ ***DATE:*** ____________________

PARENT/GUARDIAN SIGNATURE: ____***DATE:***____________________

CANCELLATION FORM

Please read carefully and sign.

At Fremont Therapy & Wellness, we are passionate about goal setting and know that your recovery will be most successful when we work together. As our patient, you become part of the Fremont Therapy & Wellness family, and together we will set attainable goals to move forward and make your aspirations a reality. Our strategic 1:1 scheduling and individualized sessions with therapists and NOT techs/aids and are designed to optimize your success while minimizing setbacks and regressions.

Keeping all your regularly scheduled appointments is critical to not only the extent of your recovery, but also to the speed with which you will be able to return to your activities and passions. **This is the most important reason as to why we have a cancellation policy.**

Our cancel/no show policy is listed below:

Less than 24 hour Cancel/No Show Policy: Please call *24+ Hours in Advance* to cancel your appointment or you may be subjected to a *$35 LATE FEE* will be applied to your account for each appointment you No Show or call to cancel the day of the appointment.

- *Rescheduled* appointments that are within the same treatment week *WILL NOT* be charged the late fee.
- Each patient will receive *ONE FREE* *Cancellation/No Show* (per Month) where the fee will be waived.
- After cancelling 3 visits in less than 24 hours (without rescheduling), our office will contact you regarding setting up future scheduling requirements. Cancellations and no-shows are documented in your medical record.

*Patient is responsible to pay this fee as it will not be covered by your insurance companies

Cancellations due to poor weather or having Covid will not count against you. In the event of a poor weather forecast, you will not be required to provide 24 hours' notice and *we encourage you to keep your scheduled appointment until you determine that it is no longer safe* to come to therapy. We also encourage you to reschedule these appointments the next day or later in the week.

Things to keep in mind if you need to cancel:

- **Do not** cancel by e-mail or text.
- Call your clinic to leave a message or speak to a staff member.
- If we can re-schedule you **within the same week**, it will not be considered a late cancel.
- If you need to cancel a Monday appointment, you must leave a message at the clinic 24 hours prior.

I understand the above cancellation policy.

Print Name: ____ Date: _________________

Signed ____

CREDIT CARD ON FILE FORM

Patient's Last Name: _________________________________ First: ________________________DOB: _____ /_____ /____

Fremont Therapy & Wellness will keep a **"Credit Card On File"** scanned into your locked electronic private chart during your episode of care. ***This card will be used for the following things:***

1. ***A $35 LATE FEE*** will be applied to your account for each appointment you ***NO SHOW*** or call to cancel the day of the appointment. ***Rescheduled*** appointments within the same treatment week ***WILL NOT*** be charged the late fee. Each patient will receive ***ONE FREE*** ***Cancellation/No Show (per Month)*** where the fee will be waived. After cancelling 3 visits in less than 24 hours without rescheduling, our office will contact you regarding setting up future scheduling requirements. Cancellations and no-shows are documented in your medical record.

2. **Payments toward deductible**: Patients with a deductible that has not been met will be charged ***$75 per visit*** that is ***applied to the visit cost towards their deductible.***

3. **Balance Remaining:** For patients with a remaining balance 60 days after being discharged, FTW will charge the full amount to the credit card we have on file.

Credit Card Authorization

Credit Card Type (***Check One***): Visa ________MasterCard ________Discover _______ American Express__________

Account Holder: First Name: _______________________________________Last Name: _________________________

Credit Card #____Expiration Date: ____/____

CV code: __________ Zip Code: ____________________

☐ I hereby authorize Fremont Therapy & Wellness to charge my credit card account for late fees, payments towards deductible & any/all remaining balances due. In the event that my card is declined, FTW may require additional card information in order to keep my account current.

This authority will remain in effect until I notify Fremont Therapy & Wellness in writing otherwise. If I change the account or financial institution specified above, I will provide Fremont Therapy & Wellness with new financial institution/credit card information. In addition, I have the right to notifying Fremont Therapy & Wellness regarding stopping any payments before the account is charged. I understand Fremont Therapy & Wellness reserves the right to terminate this payment plan and/or my participation therein.

PATIENT SIGNATURE: ____ ***DATE:*** __________________

PARENT/GUARDIAN SIGNATURE: ____***DATE:*** __________________