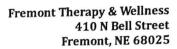


Patient Information Form & Consent to Treat

Full Name:			Preferred Name:			
				Age:		
Street/Mailing Address:						
City:						
Email:						
Appointment Ren	ninders - Preferred	l Method (circle)	: Text Message/ Email/ N	No Reminders		
Emergency Contact:			_ Relationship:			
Phone Number:			_			
Referring Physician:			Location:			
Primary Care Physician (if different):						
How did you hear about us (circle)?	Please specify, se	o we can say "Th	aank You!"			
Family/Friend:			_ Google/Facebook	Past Patient		
Doctor (please list):			_ Insurance Network	Work Comp		
Consent to Treat/HIPAA Consent: I consent to physical and/or occupational therapy care and treatment considered necessary and proper in evaluating or treating my physical condition as part of my plan of care. CONSENT TO TREAT A MINOR: As parent and/or legal guardian, I authorize Fremont Therapy & Wellness to treat the minor patient named on this form while I am not present.						
I acknowledge & agree that I have been the Notice of Privacy Practices. I herel information regarding my therapy trea understand that the identity of designa	oy authorize the Deatments, accounts/	esignated Parties payments and/or	Below to request/receiv r administrative operation	re any/all of my protected health ons related to my care. I		
Name:			Relationship:			
Name:			Relationship:			
By signing below, I agree that all of a provide me with therapy services and treatment and care.	he above informat d to furnish my pl	tion is correct, a hysician, insurar	nd that I authorize Fren nce company or attorne	nont Therapy & Wellness to y information related to my		
Patient Signature:				Date:		
Parent/Guardian Signature:				Date:		





Patient Medical History Form

Full Name:					Height:	Weight:	_
Type of Injury/Condition:					Date of Injury/	Onset:	_
Type of Surgery/Procedure (i	f applicable):				Date of Surg	gery:	_
Referring Provider:			Pı	rimary Care Prov	rider:		
Have you seen anyone else for Physician/MD Dentist			on? (Circle all that apply) Podiatrist Physical Therapist		Orthopedic Surgeon Other:		
Medical History: Have you e	ver had any of the foll	lowing	condition	ns/diagnoses? (C	ircle all that apply		
High Blood Pressure	Heart Condition		Stro	ke	Osteoporosis		
Peripheral Neuropathy	Seizures/Epilep	Seizures/Epilepsy		n Problems	Diabetes: Type	1 / Type 2	
Hearing Problems	Fainting/Dizzin	Fainting/Dizziness		ysema/COPD	Frequent or Se	vere Headaches	
Bladder/Bowel Problems	Arthritis	Arthritis		na	Parkinson's		
Multiple Sclerosis	Cancer:	-	_	Other:			
Have you had any falls in the	past year?	YES	NO	If so, about ho	ow many?		-
Do you have a history of fract	ures?	YES	NO	Where?			
Do you have any metal implants? (ex: pacemaker)		YES	NO	Where?			_
Do you smoke?		YES	NO	How much pe	r day?		
Do you exercise regularly?		YES	NO	How often?			_
Do you have any known allergies?		YES	NO	Please list:			_
Are you pregnant or think that you might be?		YES	NO				
Medications: Please list any	medications (prescri	bed or o	ver-the-c	counter) or suppl	lements that you a	re currently taking:	
Surgeries: Please list all surg	geries including date/	/year:					_
Diagnostic Tests: (Please circ	cle any tests or proce	dures th	nat have l	been done for yo	ur current conditi	ion.)	
X-rays	MRI		CT Sca	an	Bone Scan		
EMG	Blood Work		Bone	Density	Ultrasound		
Patient Signature:					Date:		
Parent/Guardian Signature					Date		





Payment and Insurance Policy

Financial Policy:

It is our policy to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. We ask that you make copayments, co-insurance and payments towards deductibles at the time of each visit. It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status.

Insurance Patients:

I hereby authorize Fremont Therapy & Wellness to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Fremont Therapy & Wellness. If your insurance changes, please notify us as soon as possible.

Any patients who have not met their insurance deductible will require a \$75 payment towards their deductible at time of each visit until their deductible is met. The remaining balance will be billed after the insurance claims process.

Self Pay Patients:

Physical Therapy and Occupational Therapy self pay cash rates: Initial Evaluation \$125 and Follow-Up treatments \$100 per visit.

Dry Needling Cash Rate: \$45 per body region per treatment session for dry needling sessions only; \$15 additional charge per treatment session while participating in therapy.

Shockwave (EPAT) Cash Rate: \$250 package for evaluation with three shockwave treatments. Additional shockwave treatments are \$75 per treatment for shockwave therapy only; \$35 additional charge per treatment while participating in therapy.

High Balances:

If your account exceeds a balance of \$350, we ask for you to pay as much of the balance as soon as possible via check, credit card, HSA account or arrange for a payment plan to be made.

Nonpayment of Balance:

Patients who have received three consecutive statements and have not made a payment towards their balance will receive a reminder letter and phone call to set up a payment plan. If no payment has been made by the fourth mailed statement, your account may be turned over to a collection agency.

Cancellation Policy

At Fremont Therapy & Wellness, we are passionate about goal setting and know that your recovery will be most successful when we work together. Our strategic 1-on-1 individualized treatment sessions with therapists 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.

Cancellation/No Show Policy

If you schedule an appointment and cancel less than 24 hours of your appointment time, this is considered a Late Cancellation and we reserve the right to charge you a \$35 Cancellation Fee. If you schedule an appointment and do not come to your appointment, we reserve the right to charge you a \$35 No-Show Fee. Cancellation and No-Show Fees are not billable to any form of insurance. In instances of non-compliance with your scheduled visits, we reserve the right to discontinue your care.

After three Late Cancels or No-Shows, you will be notified by our office regarding that any future visits will be removed from the schedule. If you are wanting to schedule an appointment, you will need to call the office that same day to see if there is availability for an appointment,

If you need to cancel a session, rescheduled appointments within the same treatment week will not be charged a late fee. By signing below, you acknowledge that you have read, understand and agree to all the policies listed above.

Patient/Guardian Signature:	Date: