MOVEMENT ARTS PHYSICAL THERAPY
LAUREN FOX MPT, GALEN OKAZAKI MPT
2239 TOWNSGATE ROAD, SUITE 101 WESTLAKE VILLAGE, CA 91361
805 497-0388 www.movementartsphysicaltherapy.com

PATIENT NAME: LAST_____FIRST_____MI____

DATE OF BIRTH:_____AGE_____GENDER_____ MARITAL STATUS_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE NUMBER: HOME ☐_____MOBILE ☐_____WORK ☐_____

(PLEASE CHECK PRIMARY CONTACT NUMBER)

EMAIL ADDRESS:_____

EMERGENCY CONTACT: NAME_____PHONE NO._____

EMPLOYER NAME:_____PHONE NUMBER:_____

REFERRING PHYSICIAN:_____PRIMARY PHYSICIAN: _____

SELF REFERRED YES NO HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DATE THIS ISSUE STARTED:_____

REASON FOR VISIT:

PREVIOUS MEDICAL HISTORY:

PLEASE LIST ANY MEDICATIONS/ SUPPLEMENTS YOU ARE TAKING (INCLUDING DOSAGE, METHOD AND FREQUENCY):

• Cancellation policy

Appointment cancellations with less than 24 hour notice and no shows will be charged at 50% of appointment price.

Client/Guardian Signature: _____Date: _____

PATIENT CONSENT TO TREAT

I authorize Movement Arts Physical Therapy to render appropriate treatment provided by appropriate personnel and understand that I have the right to refuse treatment.
Initial_____

I authorize Movement Arts Physical Therapy to obtain or provide emergency care if conditions warrant while at the facility if I am unable to give consent (CPR/emergency care).
Initial_____

Patient Rights/Expectations:

1. To be informed of the nature of their conditions, proposed treatment, and expected risks and results.
2. To be a participant in the plan of care and informed about the treatment plan. This includes refusal of all or part of the suggested treatment plan after being informed of any potential consequences of participation in the treatment plan.
3. To voice any grievances regarding care or treatment.

Clinic Rights/Expectations:

1. To obtain a complete and accurate medical history and any other necessary information in a timely fashion.
2. Patient will read and understand or ask questions regarding any forms or documentation.
3. Patient will participate in the plan of care and adhere the treatment plan, including home program.
4. Patient will immediately report to the therapist any stress or discomfort that may be elicited during treatment.
5. Patient will be present and on time for appointments.

Client/Guardian Signature: _____Date:_____

WE ARE NOT IN NETWORK WITH ANY INSURANCE COMPANIES

We are not affiliated with any insurance companies. If you have out-of-network private insurance benefits, we can provide a superbill, upon request, that you can submit to insurance. **WE ARE NOT MEDICARE PROVIDERS, OUR SERVICES ARE NOT COVERED BY MEDICARE**. By receiving care at our facility, you are agreeing to services not covered by Medicare.

Client/Guardian Signature: _____

HIPAA FORM

I acknowledge that I have been presented with a copy of the MAPT Notice of Privacy Practices form as required by the Health Insurance Portability and Accountability Act of 1996. (see laminated page)

Client/Guardian Signature: _____Date:_____