WHAT TO EXPECT AT YOUR FIRST VISIT

Longevity Physical Therapy will redefine your patient care experience.
We aim to excel in service and experience. We strive to exceed your expectations!

What to Wear on Your First Visit?

Please wear comfortable and athletic clothing. Closed toe shoes, preferably tennis shoe/sneaker. Arrive 15 minutes early to your scheduled appointment to complete all required paperwork and answer any questions you may have.

What Should I Bring?

- Completed paperwork
- Insurance card
- Physician's prescription for physical therapy, if you have one

What Happens During My First Visit at Longevity Physical Therapy?

Your First Visit will last approximately 60-75 minutes. This will be an in-depth one on one evaluation with your Physical Therapist combining innovative technology and clinical expertise to understand the underlying cause of pain/movement dysfunction. The intent of the first visit is to create an individualized and specific road map for the Physical Therapist and patient to follow in order to achieve each patient's goals.

The therapist will discuss the following:

- Your medical history.
- Your current problems/complaints.
- Pain intensity, what aggravates and eases the problem.
- How this is impacting your daily activities or your functional limitations.
- Your goals with physical therapy.
- Medications, tests, and procedures related to your health.

The therapist will perform a variety of assessments understand the symptoms you are experiencing and just as importantly to devise a comprehensive program to treat the underlying cause of your problems. A plan is subsequently developed with the patient's input. This includes how many times you should see the therapist per week, how many weeks you will need therapy, home programs, patient education, short-term/long-term goals, and what is expected after discharge from therapy. Each patient will go home a pictures and or video of an individualized Home Exercise Program to help the patient achieve their goals as quickly as possible. This plan is created with input from you, your therapist, and your doctor.

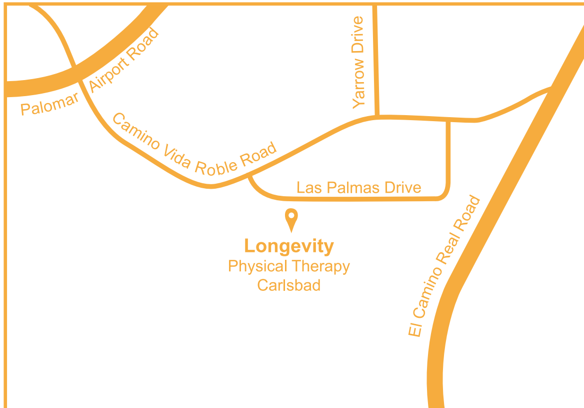
Please call us with any questions or concerns you may have. We look forward to adding LONGEVITY to your life.

CARLSBAD—NORTH COUNTY
2077 Las Palmas Drive, Carlsbad, CA 92011
Phone: 760-918-9200 • Fax: 760-918-9203

MISSION GORGE—SAN DIEGO
4635-B Mission Gorge Place, San Diego, CA 92120
Phone: 619-501-9037 • Fax: 619-501-9038

LONGEVITY
physical therapy

LOCATIONS & LONGEVITY PT STAFF



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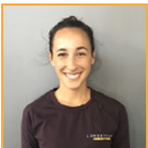

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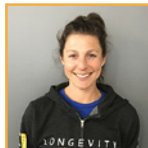

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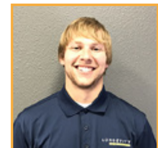


TANNER CRASS
DPT, PT, CSCS
Mission Gorge
Doctor of Physical Therapy
tanner@longevityphysicaltherapy.com

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*

L O N G E V I T Y

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.**

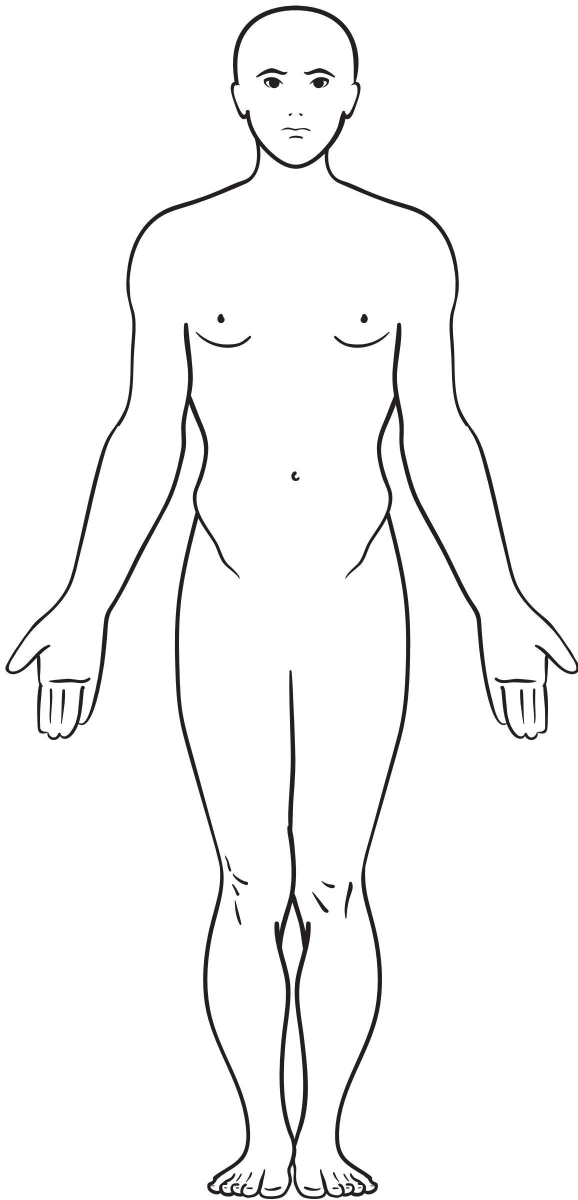
Do you smoke? ❑ Yes ❑ No	Alcohol Consumption: Daily Weekly Occasionally Rarely Never	
Please list any allergies you have:		
Are you pregnant? ❑ Yes ❑ No	Have you experienced recent unplanned weight loss? ❑ Yes ❑ No	
Do you have asthma? ❑ Yes ❑ No	Do you wear a pacemaker? ❑ Yes ❑ No	Metal implants? ❑ Yes ❑ No

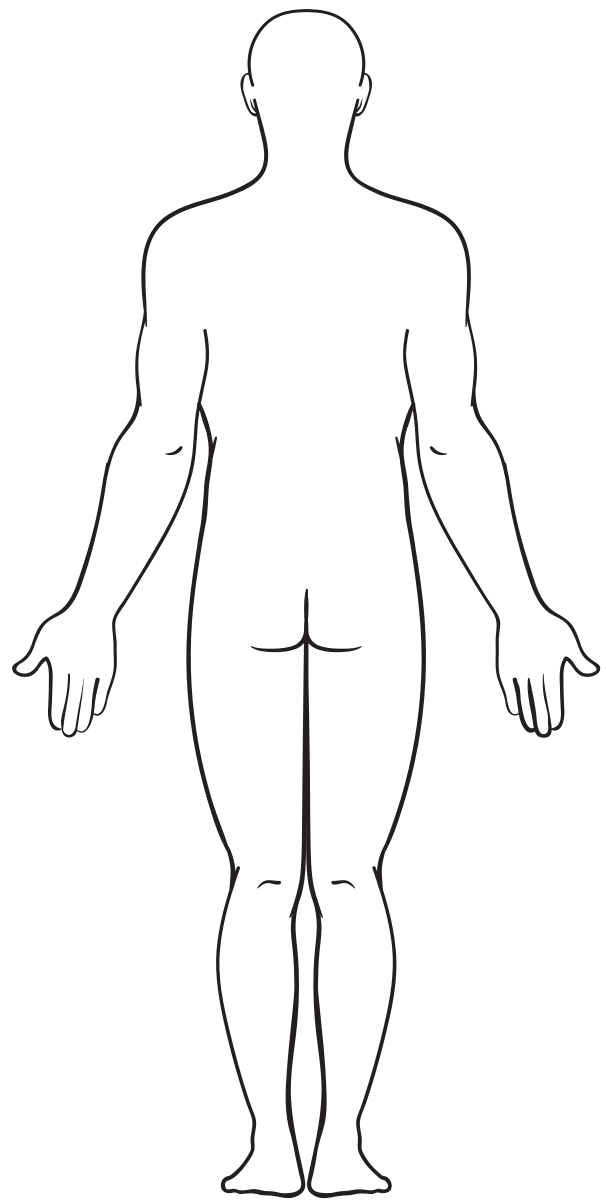
I affirm the above information accurate to the best of my knowledge.

Patient/Guardian Signature *Date*

LONGEVITY

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

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.

Authorization for release of Medical Records

I authorize the Provider to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination renders to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Provider deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person organization without a further authorization signed by me for release of the information.

Electronic Submission of Medical Information

I understand if I want a copy of my medical information or financial account history I will have the opportunity to provide my verbal authorization to receive that information via email at the time of the request. Email is not considered secure by HIPAA guidelines. My signature on this form indicates my understanding that by opening such an email, I gave my verbal authorization to receive, I have also given written authorization. I am aware of any risk this may pose to my Personal Health Information.

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 2077 Las Palmas Drive, Carlsbad, CA 92011

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

L O N G E V I T Y
physical therapy

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 and any administrative operations related to treatment or payment. 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) ____

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.

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** ___ **Mastercard** ___ **Discover**

Name on Card ____ ________________________

Account# _____________________________________ **Expiration**_________ **Security** ________

Billing Address ____

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.**

PATIENT TREATMENT AGREEMENT

Cancellation Policy. I understand that if I cancel my scheduled appointment with less than 24 hours' notice, or fail to show up for a scheduled appointment, 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. _______ (initial)

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. Attached is a copy of your insurance verification form which details the benefits that Longevity Physical Therapy confirmed for you. ________ (initial)

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________ (initial)

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. . ________ (initial)

I understand and agree that I may be photographed or videotaped while receiving physical therapy for purposes of advertising and or social media. However, in the event that I do not wish to be videotaped or photographed, I will notify Longevity Physical Therapy. _______ (initial)

I agree that I have read, understand and agree to the terms listed above and that I have been advised to seek legal counsel in the event that I do not understand any of the above..

Printed Name________________________________ Date _____________________

Signature ___________________________________

LONGEVITY
physical therapy

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, 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 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. 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.

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

PRINT NAME ____________________________ SIGNATURE __________________________

DATE ___________________________________

If under 18 years of age:

PARENT or LEGAL GUARDIAN NAME AND SIGNATURE _________________________________

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