CLAWSON PHYSICAL THERAPY

1075 Fulton Avenue, Suite A
Sacramento, CA 95825
916.488-4000
916.488-4005

6915 Elk Grove Blvd., Suite A
Elk Grove, CA 95758
916.684-3000
916.684-3003

Medical History

Personal Information

First Name:	Init:	Last Name:
Date of Birth:	Social Security #:	Marital Status: ☐Married ☐Single ☐Widow
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email Address:		
Spouse/Caregiver Name:		
Spouse/Caregiver Home Phone:	Cell Phone:	

Insurance Information

Financial Responsible Party Name:		☐ Check if Self	
Financial Responsible Party Street Address:			
City:	State:	Zip Code:	
Primary Insurance:	ID#	Group#	Copay Amount:
Secondary Insurance:	ID#	Group#	Copay Amount:

***Please provide copy of insurance cards**

Medical Doctor Information

Prescribing Doctor Name:		Phone: FAX:	
Address:	City:	State:	Zip:
NPI:			

Office use only

Case Title: ICD10:

CLAWSON PHYSICAL THERAPY

Medical History

Current injury/illness:	Date of onset: Date of Surgery: (if applicable):

Prior Hospitalization? ☐ From: / / to / / at hospital.
Prior SNF stay? ☐ From: / / to / / at SNF.

Are you currently receiving **In Home Physical Therapy**? ☐ Yes ☐ No. If you had home health this year, please list the name of the agency: _____.
Have you had **Outpatient Physical Therapy** for this issue this year?

When?	Where?

Check all that you have had or still have:

☐Stroke ☐High Blood Pressure ☐Hip Replacement L or R ☐Knee Replacement L or R ☐Fracture(s)
☐Cancer ☐Respiratory Problems ☐Heart Problems ☐Pacemaker ☐Parkinson's
☐Diabetes ☐Seizures ☐Food Allergies OTHER: _____

Height_____ Weight _____ BP _____/_____ _____

Check all that apply

Is the patient having difficulty walking? ☐ Yes ☐ No Pain with walking? ☐ Yes ☐ No

Does the patient use a : ☐ cane ☐ walker ☐ wheelchair ☐ any type of brace

Does the patient have any of the following at home: ☐steps ☐stairs ☐ramp

Does the patient need assistance with transfers? ☐ Yes ☐ No How much? ☐ 1 person ☐ 2 person ☐ Hoyer

How did you hear about CLAWSON PHYSICAL THERAPY? _____

I certify that all of the above information is true and accurate to the best of my knowledge:

Signature of Patient/Responsible Party_____ Date:_____

Clawson Physical Therapy

INSURANCE RELEASE

Name _____ Birth date _____

Social Security # _____-_____-_____Driver's License # _____

Insurance Company _____Member ID# _____

Secondary Insurance _____Member ID# _____

Doctor's Name and Phone # _____

With regards to medical care and services provided, it is agreed that David T. Clawson, MPT and Clawson Physical Therapy, it's Physical Therapists and Physical Therapy Assistants provide medical care and services to the patient such as: physical therapy and any other services deemed necessary and rendered to the patient by David T. Clawson, MPT, Clawson Physical Therapy, staff, physical therapists, physical therapy assistants, according to the best of their skill and knowledge.

David T. Clawson, MPT and Clawson Physical Therapy will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when David T. Clawson, MPT and Clawson Physical Therapy is permitted or required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, David T. Clawson, MPT and Clawson Physical Therapy may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of David T. Clawson, MPT and Clawson Physical Therapy's charges, including but not limited to insurance companies, health care service plans, or workers' compensation carriers.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay for services, including any balances remaining after all benefits have been paid. Should the account be referred to an attorney or collection, the undersigned will pay actual attorney's fees and collection expenses.

MEDICAL ASSIGNMENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient direct payment to David T. Clawson, MPT and Clawson Physical Therapy of any insurance benefits otherwise payable to or on behalf of the undersigned for all services. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

I understand that I have the right to a copy of this agreement and waive same unless requested at the time of signing.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is fully authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ **Date**_____

Patient / Guardian / Conservator

STATEMENT OF INTENT TO BEGIN PHYSICAL THERAPY AND AGREEMENT TO PAY FOR SERVICES

Date: _____

David T. Clawson, MPT dba Clawson Physical Therapy

Clinic Locations:

Sacramento Office
1075 Fulton Avenue, Suite A
Sacramento, CA 95825
Phone: (916) 488-4000

Elk Grove Office
6915 Elk Grove Blvd, Suite A
Elk Grove, CA 95758
Phone: (916) 684-3000

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1. IDENTIFICATION OF PATIENT

Patient Name: _____
Date of Birth: _____
Address: _____

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2. PURPOSE

This document serves as formal authorization and agreement for the initiation of physical therapy services for the above-named Patient. This document is made and signed by:

- The **Patient**, if competent and capable of giving informed consent; and/or
- The Patient's **Agent** under a valid **California Advance Health Care Directive**, **Power of Attorney**, or court-appointed **Conservator/Guardian** authorized to make medical and financial decisions under California law.

3. CONSENT TO TREATMENT

Pursuant to **California Health & Safety Code §§ 123110–123148** and **Business and Professions Code § 2620**, we hereby consent to the provision of physical therapy services by **David T. Clawson, MPT, dba Clawson Physical Therapy**, at either of the locations listed above. Services may include, but are not limited to:

- Physical evaluations and assessments
- Therapeutic exercises and modalities
- Manual therapy
- Functional mobility training
- Other medically necessary treatments within the scope of California-licensed physical therapists

We understand the nature and purpose of these treatments, and consent is given voluntarily and without coercion.

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4. LEGAL AUTHORITY (IF SIGNED BY A REPRESENTATIVE)

If this form is being signed by a representative of the Patient, the undersigned affirms they are authorized to act under:

☐ A valid **California Durable Power of Attorney for Health Care**
☐ A valid **General Power of Attorney with medical/financial authority**
☐ A court-issued **Letters of Conservatorship/Guardianship**
☐ As the **closest available next of kin** under emergency consent provisions (Health & Safety Code § 1418.8)

☐ *A copy of the authorizing legal document is attached*

Under **California Probate Code §§ 4000–4465**, such agents may make healthcare and/or financial decisions on behalf of the Patient as authorized by law.

5. FINANCIAL RESPONSIBILITY

The Patient and/or Legal Representative agrees to:

- Be financially responsible for all charges related to physical therapy services rendered by **David T. Clawson, MPT, dba Clawson Physical Therapy**, including services not covered by insurance.
- Pay for deductibles, co-pays, co-insurance, or any non-covered services.
- Comply with Clawson Physical Therapy's payment and billing policies, and understand that late or non-payment may result in additional fees or collection activity, consistent with **California Civil Code §§ 1788–1788.100**.

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6. INSURANCE INFORMATION (IF APPLICABLE)

☐ The Patient will use health insurance:
Insurance Provider: _____
Policy/ID Number: _____
We understand we are responsible for all amounts not paid by the insurer.

☐ The Patient will **self-pay** for all services rendered.

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7. ACKNOWLEDGMENTS

We acknowledge and agree to:

- Follow all clinic policies regarding treatment, cancellations, and billing
- Participate in treatment voluntarily and with informed understanding
- Authorize **David T. Clawson, MPT, dba Clawson Physical Therapy** to provide physical therapy in accordance with California law and best practices

8. SIGNATURES

Patient Signature (if able): _____
Printed Name: _____
Date: _____

Legal Representative/POA Signature: _____
Printed Name: _____
Relationship to Patient: _____
Phone Number: _____
Date: _____

☐ *POA / Conservatorship / Legal Document Attached*

Clinic Representative/Witness (if required): _____
Printed Name: _____
Date: _____