Whom may we thank for referring you?

☐ Doctor_____ ☐ Family Member_____

☐ Friend_____ ☐ Website _____ ☐ Other_____

General Information

Last Name:		**First Name:**		**Middle Name:**	
Birth date: / /	**Sex:** ○ Male ○ Female	**Age**	**Home Phone Number:**	**Cell Phone Number:**	
Street Address:		**City:**	**State:**	**Zip:**	
Email Address:		**Primary Care Physician:**		**Physician Phone Number:**	
Occupation:		**Employer**			

Do you have a prescription: ○ Yes ○ No	**Prescription Date:**	**Prescription frequency/# of visits:**

What is the injury/surgery:	**Date of onset/date of surgery:**
Previous treatment:	

The above information is true to the best of my knowledge. I consent to treatment for physical therapy and strength and conditioning from Mobility Rx. I understand that I am financially responsible for any and all charges.

Patient/Guardian Signature: _____ Date: _____

Mobility Rx
Tel: (949) 484-6623 Email: david@mobility-rx.com

Patient/Client Name:_____

Have you ever experienced any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Anemia/blood Disorder	☐	☐	Stroke	☐	☐	Sensitivity to Ice	☐	☐
Arthritis	☐	☐	Falls	☐	☐	Sensitivity to Heat	☐	☐
Bowel/bladder problems	☐	☐	Gynecologic Conditions	☐	☐	Lung Disorder	☐	☐
Cancer	☐	☐	Headaches (>1 per week)	☐	☐	Neurological Disorder	☐	☐
Depression	☐	☐	Hearing Problems	☐	☐	Osteoarthritis	☐	☐
Diabetes	☐	☐	Hernia	☐	☐	Osteoporosis	☐	☐
Dizziness	☐	☐	Kidney Problems	☐	☐	Rheumatologic Disorder	☐	☐
Arterial Blockage of Legs	☐	☐	Liver/Kidney Condition	☐	☐	Thyroid Condition	☐	☐
Deep Venous Thrombosis	☐	☐	Head Trauma	☐	☐	Vision Problem	☐	☐
Heart Disease	☐	☐	Fractures	☐	☐	Have a pacemaker	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐	Have metal implants	☐	☐

Medications Currently Taking	**How much/how often**
1.	
2.	

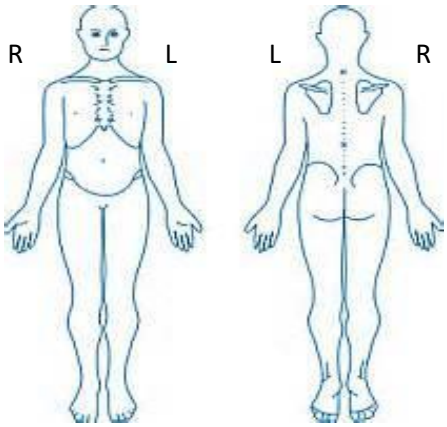
Please list any allergies you have-

Do you smoke? Yes☐ No☐ Alcohol consumption:☐ daily ☐weekly☐occasionally☐rarely☐never

Are you pregnant? Yes☐No☐ Have you experienced recent unplanned weight loss? Yes☐ No☐

Describe Diagnosis/Injury:

Please mark the area of discomfort



Rate the intensity of the pain at its <u>best</u>

0 (none)

Which description are you experiencing?

☐ Aching ☐ Numbness ☐ Stabbing

☐ Burning ☐ Dull ☐ Pins and Needles

The above information is correct to the best of my knowledge.

Patient/Guardian Signature:_____Date:_____

Mobility Rx

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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.

Mobility Rx's Legal Duty

Mobility Rx is required by law to protect the privacy of all patient health information. This policy states that all individuals shall adhere to HIPAA regulations and protect our patient's personal health information at all times. Patient information will not be used outside of below disclosures without an authorization from the patient.

Uses and Disclosures of Health Information

Mobility Rx 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.

Mobility Rx 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.

Mobility Rx may change their 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

As my patient and/or client, 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 operations. You may request in writing that we do not use or disclose your personal health information for treatment, payment, and operations except when specifically authorized by you, when required by law or in emergency circumstances. Mobility Rx will consider all such requests on a case-by-case basis, but is not legally required to accept them.

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 regarding HIPAA regulations, please contact Mobility Rx.

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

Mobility Rx
Tel: (949) 484-6623 Email: david@mobility-rx.com

Patient Information Consent

I have read and fully understand Mobility Rx's Notice of Information Practices. I understand that Mobility Rx 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. 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 notified, Mobility Rx 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 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 is a minor) _____

Mobility Rx
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Late cancellation/No-show

We request that you notify us by phone or email, **at least 24-hours** prior to your scheduled appointment. If you fail to keep your appointment or do not cancel 24-hours prior to your appointment time, you may be subject to a **$50** late cancellation/no-show fee.

(Initial) _____

All notice must be given in the form of a phone call/voicemail to (949-484-6623)
or email (david@mobility-rx.com).

Financial Responsibility

As a courtesy, Mobility Rx will verify cost of services provided. However, the patient/client assumes full responsibility for payment of cash services as Mobility Rx does not accept payment from insurance companies. All patient cash services are due at the time of treatment. We do not accept liens under any circumstances.

(Initial)_____ I hereby understand I am financially responsible and obligated to pay for all charges related to the services provided.

I understand the terms of this form and hereby state that I am financially responsible for charges incurred from cancellations or no shows, as well as take full financial responsibility for any and all services provided.

Patient/Guardian Signature: _____ Date: _____