the wellness bank
INVEST IN YOUR HEALTH

phone: 424.247.9112
fax: 310.882.6426
email: info@thewellnessbank.com
web: www.thewellnessbank.com

Client Information

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email_____

Employer / School_____ Occupation / Sport_____

How did you hear about The Wellness Bank?_____

Referring Physician_____

Area(s) to be treated _____

Date of Injury / Onset of Pain_____ Date of Surgery_____

Emergency Contact

Name_____ Phone_____

Parent or Guardian (if under 18)

Name_____ Relationship_____

Address_____

Phone_____

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Please initial and sign at the bottom.

_____(initial) ***Privacy Policy:*** I have read the Health Information Privacy Policy attached.

_____(initial) 48 ***Hour Cancellation Policy*****:** Your appointments are one-on-one with your practitioner, therefore please provide at least 48 hours notice to reschedule or cancel. Your appointment time is reserved exclusively for you. Late cancellations will be charged to the card on file $100.

_____(initial) ***Billing***: All payments, including insurance co-pay and deductible, will be collected at the time of service. Your co-pay is often an estimation of your cost, based on the benefits quoted by your insurance company. The Wellness Bank will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nonetheless, it is ultimately your responsibility, its benefits and the obligations are placed on you. It is not the responsibility of The Wellness Bank to verify your insurance coverage or determine which services are or are not covered. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

_____(initial) ***Insurance Payments***: Some insurance companies reimburse the patient directly instead of the provider. You may receive insurance reimbursement checks from your visits directly. It is your responsibility to cash or deposit these checks in a timely manner and submit the same amount (via cash, check or credit card) to The Wellness Bank within 7 days of receiving the insurance reimbursement.

_____(initial) ***Balances Due***: As a courtesy, we will verify your insurance coverage for physical therapy services in our office. While we make every effort to accurately estimate your financial obligation (copay/deductible), insurance companies will not guarantee benefits/payment amounts for non-participating providers, and therefore a balance due may remain, once insurance processes your claim. We will send a billing statement to both the mailing and email addresses you provide in your new patient paperwork. Should you neglect to pay the amount due within 30 days, a 1% monthly interest/finance charge will be applied to your outstanding balance and will reflect on the subsequent billing statement (12% APR).

_____(initial) ***Direct Access:*** (Only for Physical Therapy patients without a prescription): You may receive direct physical therapy treatment services for 12 visits or 45 days (whichever comes first), after which a a physician's signature is required on the Physical Therapist's plan of care or a written prescription.

_____(initial) ***Prescriptions:*** (Only for Physical Therapy patients): It is your responsibility to keep your prescription up to date or request an updated one from your referring doctor every 90 days.

Signature_____ Date_____

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General Health Questionnaire

Do you currently experience any of these symptoms?

Fevers / chills / sweats	☐ Yes	☐ No
Unexplained weight loss / gain	☐ Yes	☐ No
Malaise (feeling generally unwell)	☐ Yes	☐ No
Unusual fatigue	☐ Yes	☐ No
Nausea / vomiting	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizziness / lightheadedness / loss of consciousness	☐ Yes	☐ No
Blurred vision	☐ Yes	☐ No
Numbness / tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Muscle cramping	☐ Yes	☐ No
Chest pain / palpitations	☐ Yes	☐ No
Swelling in feet or hands	☐ Yes	☐ No
Difficulty breathing / shortness of breath	☐ Yes	☐ No
Difficulty breathing when lying down	☐ Yes	☐ No
Cough / change in cough/blood in phlegm	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Heartburn / indigestion	☐ Yes	☐ No
Change in appetite	☐ Yes	☐ No
Specific food intolerance	☐ Yes	☐ No
Bowel pattern changes (color, texture, frequency)	☐ Yes	☐ No
Difficulty urinating (starting, stopping)	☐ Yes	☐ No
Urine frequency changes	☐ Yes	☐ No
Possibility of pregnancy	☐ Yes	☐ No

Other medical conditions or prior surgeries:_____
_____

Current medications:_____
_____

Family medical history (birth parents and siblings):_____
_____
_____

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Consent to Treatment

Physical therapy and Chiropractic are patient care services provided in response to a wide range of medical care needs of patients of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy and chiropractic is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization / manipulation, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

We would appreciate your full cooperation with the evaluation and treatment program. Because of the nature of services provided, you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times. Should you feel uncomfortable or embarrassed, you may refuse or stop the procedure.

There are certain inherent risks with treatments because you will be asked to exert effort and perform activities with increasing degree of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort of pain. We will take every precaution necessary to ensure you are protected from any potentially hazardous situation. You will never be forced to perform any procedure you do not wish to perform.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy and chiropractic procedures and to comply with the plan of care as it is established. I have read this consent form and authorize the release of medical information to appropriate third parties.

Signature_____ Date_____

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CREDIT CARD AUTHORIZATION

Circle one: VISA - MASTERCARD - AMEX - DISCOVER

Credit Card#_____

Expiration:_____

3 Digits on back / 4 on Front(amex): _____

Billing Address:_____

_____

24 Hours Cancellation Policy: Your appointments are one-on-one with your practitioner, therefore please provide at least 24 hours notice to reschedule or cancel. Your appointment time is reserved exclusively for you. Late cancellations will be charged to this card on file the full session amount of $150.

Signature_____

Date_____