PERSONAL PROFILE FORM

Date:_____

Your Full Name:_____ Date of Birth: _____ Age:_____ Sex: M F

Address: _____ City/State/Zip:_____

Email Address:_____ Cell Phone: _____

Emergency Contact:_____ Emergency Contact Phone #:_____

Primary Physician:_____ City/State:_____ Phone #:_____

If patient is a MINOR, parent/guardian's name and signature here: _____

FITNESS Goals: ❑ Lose Weight ❑ Body Toning ❑ Other: _____

STRESS Level : 1 low----2----3----4----5 high What's the main cause? _____

NUTRITION: What is your level of nutrition knowledge? ❑ None ❑ A little ❑ Medium ❑ A Lot

PERSONALITY TYPE: ❑ Social ❑ Emotional ❑ Intellectual ❑ Physical

Name something that is really important to you (or really enjoy doing)? _____

How did you hear about us? ❑ Google ❑ Yelp ❑ Facebook ❑ Returning Patient ❑ Doctor: _____

❑ Friend/Family:_____ ❑ Other:_____

IMPORTANT RULES & POLICIES

1. **LATE POLICY:** If more than 10-minutes, you may be rescheduled or asked to wait for the next available time.
2. **CANCELLATIONS**: A 24-Hour advance notice is required for cancelling. Otherwise, you must prepay for the next appointment.
3. **NO SHOWS:** Not showing up for an appointment (without notice) will result in a $25 fee added to your account.
4. Co-pays and/or deductibles are due prior to treatment starts.
5. Cell phones must be shut OFF or on silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason you are NOT satisfied with the care received, please call our administrator at 805-910-9913.

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Live Athletics and the physical/occupational therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, and fractures or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Live Athletics, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Live Athletics]and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Live Athletics.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE LIVE ATHLETICS FROM LIABILITY FOR PERSONAL INJURY, OR PROPERTY DAMAGE CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: _____ Signature_____ Date:_____

PRE-EXAM FORM

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

In order to evaluate your condition fully, please be as accurate as possible.

1.	Where is your pain/problem?	
2.	What caused your pain/problem?	
3.	Approximately when did it start?	
4.	List ONE ACTIVITY you aren't able to do, that you really want to do again:	
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No
6.	In your understanding, what do you think will make it better?	
7.	How optimistic are you that you'll get better? (circle one)	Not at all…….Mildly optimistic……Fairly……Very optimistic……..Extremely
8.	What are some potential obstacles to you getting better?	
9.	Over the next 30-days, how many hours per week will you commit to getting better?	
10.	What are you expecting from therapy?	
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
12.	List any medications you are taking:	
13.	List all past surgeries with dates:	
14.	List all medical conditions you have (or were told you have):	

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

Assignment of Benefits to Live Athletics

Patient Name:_____

Insurance Policy #:_____

Insured Name:_____ Insured Date of Birth_____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other:_____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Live Athletics
2488 Townsgate Unit C
Westlake Village, CA 91361
(805) 910-9913

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize Live Athletics to deposit checks made in my name.
- ❑ I authorize Live Athletics to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

HIPAA Notice Acknowledgement

Live Athletics

ACKNOWLEDGEMENT
I have received and read the Notice of Privacy Practices for the office **Live Athletics** and understand my rights contained in the notice.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

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Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with a physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient Name: _____ Date: _____

Patient or Legal Guardian Signature: _____

Print Name of Parent/Legal Guardian: _____