NEW CLIENT INFORMATION

Todays' Date: _____
Name: _____
Street Address: _____
City/State/Zip: _____
Phone: _____
Email: _____
Insurance Carrier: _____
Secondary Insurance Carrier: _____
Emergency Contact: _____
Relationship: _____ Phone: _____
Who may we thank for referring you? _____

The information above is correct and will be updated, if needed, prior to any class or appointment so that Even Keel Wellness and Physical Therapy has record of the most updated information for scheduling, billing, and/or emergency purposes.

_____ By initialing here, you indicate you have read, agree with, and understand the above statements.

EVEN KEEL
FALL PREVENTION

MEDICAL HISTORY

Do you now or have you ever had any of the following? Please check appropriate box or boxes:

☐	Asthma, Bronchitis, or Emphysema
☐	Anemia
☐	Heart Attack or Heart Surgery
☐	Chest Pain
☐	Coronary Heart Disease or Angina
☐	Gout
☐	Depression (would you like help? □ Yes □ No
☐	Dizziness or Fainting
☐	Emotional/Psychological Problems
☐	Fatigue
☐	Fever/Chills/Sweats
☐	High Blood Pressure
☐	Low Blood Pressure
☐	Shortness of Breath
☐	Diabetes I or II
☐	Thyroid Issues/Goiter
☐	Cancer/Chemotherapy/Radiation
☐	Weakness
☐	Infectious Diseases
☐	Bowel or Bladder Problems/Incontinence
☐	Allergies (specify):
☐	Elbow/Hand Injury
☐	Vision or Hearing Difficulties
☐	Stroke/TIA
☐	Back Injury/Surgery
☐	Ankle/Foot Injury/Surgery
☐	Knee/Hip Injury/Surgery
☐	Arthritis/Swollen Joints
☐	Unintentional Weight Loss/Gain
☐	Tobacco/Cigarette Use
☐	Hernia
☐	Numbness or Tingling
☐	Severe or Frequent Headaches
☐	Osteoporosis/Osteopenia
☐	Neck/Shoulder Injury/Surgery
☐	Sleeping Problems/Difficulties
☐	Blood Clot/Emboli (DVT/PE)

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FALL PREVENTION

☐	Epilepsy/Seizures
☐	Pacemaker
☐	Joint replacement of:
☐	Neurological Condition
☐	Other:

Please list all current medications: _____

_____

_____

_____

When was your last physical examination by a medical doctor? _____

What is your exercise history/experience? _____

_____

_____

_____

I have truthfully answered these questions about my medical history and condition and provided information about my current medications and medical care.

_____ _____

Signature Date

_____ _____

Relationship to Client Witness

FALL RISK ASSESSMENT TOOL FOR: _____

RISK FACTOR	LEVEL	RISK SCORE
Recent Falls	None in last 12 months	☐ 2
	One or more between 3 and 12 months ago	☐ 4
	One or more in last 3 months	☐ 6
	One or more in last three months while inpatient/resident	☐ 8
Medications (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-hypertensives, hypnotics)	Not taking any of these	☐ 1
	Taking one	☐ 2
	Taking two	☐ 3
	Taking more than two	☐ 4
Psychological (Anxiety, Depression, Cooperation, Insight or Judgement esp., re: mobility)	Does not appear to have any of these	☐ 1
	Mildly affected by one or more	☐ 2
	Moderately affected by one or more	☐ 3
	Severely affected by one or more	☐ 4
Cognitive Status (Dementia, Alzheimer's, stroke, TBI, etc.)	Intact	☐ 1
	Mildly impaired	☐ 2
	Moderately impaired	☐ 3
	Severely impaired	☐ 4
Low-Risk = 5-11 Medium Risk = 12-15 High-Risk = 16-20 **Risk Score**		

Automatic High-Risk Status: (If ticked then check HIGH below):

☐ Recent change in functional status and/or medications affecting safe mobility (or anticipated)

☐ Dizziness/Postural hypotension

Fall Risk Status: (check)

☐ Low ☐ Medium ☐ High

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FALL PREVENTION

INFORMED CONSENT & RELEASE OF LIABILITY

I am voluntarily participating in physical therapy and/or wellness services provided by Even Keel Wellness and Physical Therapy. I will be receiving instruction and information concerning fall prevention, which may include physical activity and/or home assessment and modifications recommendation. I represent and warrant that I have no physical or mental health condition that would prevent my safe participation. I agree that if I have any known medical history that may result in an adverse reaction in connection with physical activities, I will consult with and obtain the permission of a physician prior to engaging in any physical activities.

I am willingly and voluntarily assuming any risks, injuries, or damages, known and unknown, which I might incur as a result of participating in physical therapy and/or wellness services, and agree that Even Keel Wellness and Physical Therapy will not have any liability for such injuries or damages, to the maximum extent allowed by applicable law.

I acknowledge and agree that Even Keel Wellness and Physical Therapy is not a medical doctor and does not provide any medical diagnoses or treatments. I agree that if I have any medical condition, I will seek the help of a medical doctor.

To the maximum extent permitted by applicable law, I hereby (a) waive and release any claims, known or unknown, I may have against Even Keel Wellness and Physical Therapy, including its instructors, officers, directors and employees and agents, arising from or in connection with the services provided by Even Keel Wellness and Physical Therapy ("Claims") and agree to indemnify Even Keel Wellness and Physical Therapy, including its instructors, officers, directors and employees and agents, from and against any and all Claims.

As with all forms of physical therapy and wellness services, there are benefits and risks. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict the patient's response to a certain modality or activity. It is impossible to predict an individual patient's reaction to a particular treatment might be, nor can it be guaranteed that the treatment will help the condition the patient is seeking treatment. There is also a risk that the treatment may cause pain or injury or may aggravate previous existing conditions. The patient has the right to ask the physical therapist what type of treatment is planned based on medical history, diagnosis, symptoms and testing results. The patient may ask the therapist about the potential risks and benefits of a specific treatment. The patient has the right to decline any portion of the treatment at any time before or during the treatment session.

Therapeutic exercises are an integral part of most physical therapy and wellness treatment plans. Exercise has inherent physical risks associated with it. If the patient has any questions regarding the type of exercise that he/she is performing and any specific risks associated with these exercises, the therapist will be glad to answer them.

I understand the risks associated with a program of physical therapy and wellness as outlined to me and wish to proceed.

Signature	Date
Relationship to Client	Witness

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FALL PREVENTION

FINANCIAL RESPONSIBILITY

The patient is responsible for charges incurred, regardless of insurance coverage. If Even Keel Wellness and Physical Therapy has a contract with the patient's insurance carrier, Even Keel will file the claim for patient's covered services. If the insurance company denies payment for any reason, I understand that I am responsible for all balances due.

Covered services include physical therapy, which requires an individualized examination, evaluation, physical therapy diagnosis, prognosis, and intervention, including a treatment plan to treat a specific injury, pain, or dysfunction, which is deemed medically necessary. Non-covered services include wellness services, which includes general supervised exercise, movement, balance training for overall health, fall prevention classes, and home assessments. I understand that wellness treatment is not covered by insurance.

I understand, in some instances, all or some of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I understand that it is my responsibility to understand my insurance benefits and comply with the requirements of the policy.

Payment will be collected prior to or at time of service, when applicable.

_____ By initialing here, you indicate you have read, agree with, and understand the above statements

Travel Fee

Even Keel Wellness and Physical Therapy travels to treat patients within the Mendocino County north coast region, including as far south as Sea Ranch and as far north as Rockport, California. I understand that I am responsible for the agreed upon hourly rate, including drive time to and from Noyo Harbor in Fort Bragg, California. Even Keel Wellness and Physical Therapy therapists retain the right to decline admitting or treating patients who live outside the service area or decline patients who live in conditions that are not suitable for therapy or wellness due to safety reasons.

_____ By initialing here, you indicate you have read, agree with, and understand the above statements. I agree to pay the travel fee of $ 150.00 per hour from Noyo Harbor in Fort Bragg, California to my residence, as well as to Noyo Harbor in Fort Bragg, California from my residence.

_____ By initialing here, you indicate you have read, agree with, and understand the above statements, and the travel fee does not apply to me due to online services only.

Cancellations and Missed Appointments

In the event the patient/participant is unable to keep an in-person appointment please contact your therapist as quickly as possible. Visits that are cancelled within 24 hours prior to visit time or are not cancelled at all will be billed $150 due to scheduling / traveling inconveniences. E-mail or phone is a suitable means to communicate visit cancellation. In the case of a true medical emergency, the cancellation fee will be waived.

In the event a participant cannot make an online appointment or class, there will be no refund given, unless of a true medical emergency.

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CONSENT TO EMAIL/TEXT APPOINTMENT REMINDERS OR HEALTHCARE MATTERS

Patients/participants in this practice may be contacted via e-mail and / or text messaging to be reminded of an appointment, to obtain feedback on their experience with this healthcare team, and / or to provide general health reminders / information.
If at any time I provide an e-mail or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that e-mail or phone number from Even Keel Wellness and Physical Therapy staff.

1. ____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or e-mails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The e-mail that I authorize to receive e-mail messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in the patient's wireless plan (contact cell carrier for pricing plans and details).

2. ____ (Patient Initials) I hereby revoke my request for future communications via e-mail and / or text messages.
3. ____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Signature	Date
Relationship to Client	Witness

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FALL PREVENTION

PATIENT PRIVACY POLICY

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Even Keel Wellness and Physical Therapy has the right to change the Notice of Privacy Practices at any time and that I may contact Even Keel Wellness and Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that Even Keel Wellness and Physical Therapy restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Even Keel Wellness and Physical Therapy is not required to agree to my requested restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that Even Keel Wellness and Physical Therapy has taken action relying on this consent.

_____ By initialing here, you indicate you have read, agree with, and understand the above statements.