



Whom may we thank for referring you?							
<ul style="list-style-type: none"> <li>• Family Member _____</li> <li>• Friend _____</li> </ul>				<ul style="list-style-type: none"> <li>• Yelp _____</li> <li>• Google _____</li> </ul>			
First Name:		Middle Name:			Last Name:		
Birth date:	Sex: <ul style="list-style-type: none"> <li>• Male</li> <li>• Female</li> </ul>	Age:	Phone #:		Email:		
Street Address:			City:	State:	Zip:		
Employer:				Occupation:			
Emergency Contact Name:				Number:			
Primary Doctor:				Doctor's Phone #:			
What is the injury/surgery:				Date of Injury/Surgery:			
Previous Treatment(s):							

### Insurance Information (if applicable)

Insurance Carrier Name:	Subscriber/Member ID:
Insurance Card Holder's Name:	Patient's Relationship to Card Holder:

The above information is true to the best of my knowledge. I consent to treatment for physical therapy. I authorize my insurance benefits to be paid directly to No Limit Physical Therapy. **I understand that I am financially responsible for any charges not covered by my insurance at the full cash rate.** I authorize No Limit Physical Therapy to release any information required to process my claims and secure the payment of benefits.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



<b>Medications Currently Taking</b>	
Name	How much/How often
1.	
2.	
3.	
4.	
Do you smoke? Yes No      Alcohol Consumption: daily weekly occasionally rarely never	
Please list any allergies you have:	
Are you pregnant? Yes No	

**Have you ever experienced any of the following conditions?**

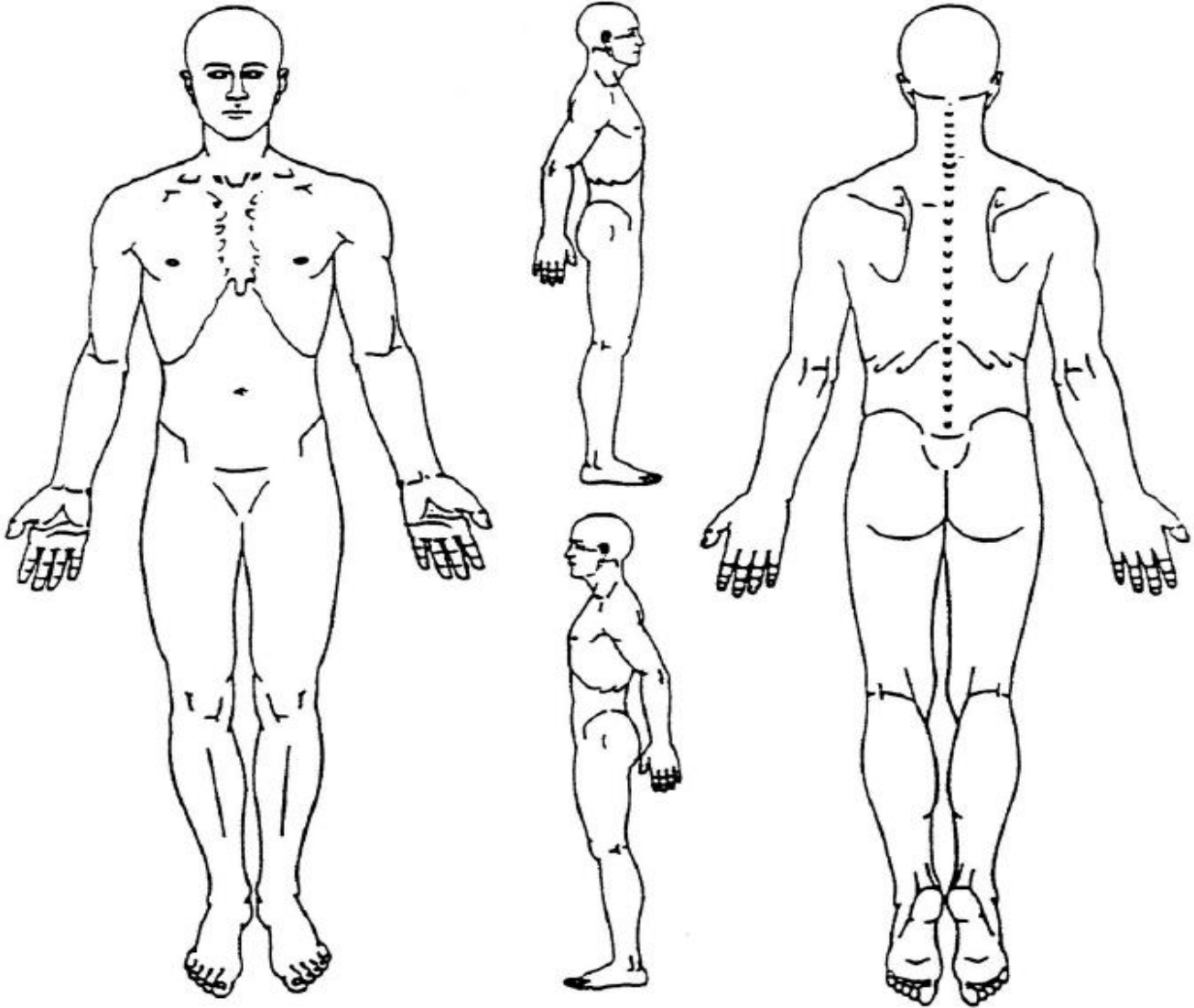
Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Asthma			Stroke			Sensitivity to Ice		
Anemia / Blood disorder			Falls			Sensitivity to Heat		
Bowel/Bladder Issues			Gynecologic Conditions			Lung Disorder		
Cancer			Headaches (>1 per week)			Neurological Disorder		
Depression			Hearing Problems			Osteoarthritis		
Diabetes			Hernia			Osteoporosis		
Dizziness			Kidney Problems			Rheumatologic Disorder		
Arterial Blockage of Legs			Liver/Kidney Condition			Thyroid Condition		
Deep Vein Thrombosis			Head Trauma			Vision Problem		
Heart Disease / Attack			Fractures			Have a pacemaker		
High Blood Pressure			Seizures			Have metal implants		
Joint Replacement			Unexplained weight loss/gain			Infectious Disease		

**List all surgical procedures you have had:**

**Other Conditions:**

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

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Circle** the area of discomfort on the body above.

Rate the Intensity of the pain at its **best** (circle): 0 1 2 3 4 5 6 7 8 9 10 (severe)

Rate the Intensity of the pain at its **worst** (circle): 0 1 2 3 4 5 6 7 8 9 10 (severe)

Which word best describes the quality of your discomfort (circle)?

Aching      Stabbing      Numbness      Burning      Dull      Pins & Needles



## CONDITIONS OF TREATMENT AND CONSENT FOR PHYSICAL THERAPY

<b>PATIENT'S INITIALS</b>	<p><b>At No Limit Physical Therapy (PT), we strive to provide you with the best 1-on-1 and individualized care. To make this possible we ask you to adhere to the very important policies below. Please read them carefully, initial all the boxes, and indicate your agreement with these policies by signing at the bottom.</b></p>
	<p><b>ATTENDANCE/COMPLIANCE and COOPERATION WITH TREATMENT:</b> I understand that for physical therapy treatment to be effective, I must attend my scheduled appointments and be ready to start on time, unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with my program, I will discuss it with my physical therapist.</p>
	<p><b>FINANCIAL POLICY (CASH PAY, if applicable):</b> For optimal patient care, No Limit Physical Therapy has chosen to be an out-of-network provider. <b>Upon your request,</b> we will give you a <b>receipt</b> of your services that you can submit to insurance for potential reimbursement if you have out-of-network insurance benefits or to apply toward your annual deductible. We cannot guarantee your reimbursements. We accept cash, debit or credit card, HSA/FSA cards, check, Venmo, Zelle, or cryptocurrency (₿ or ETH) at the time of your service (<b>cash or check is preferred</b>). The rates are as follows: \$225 for Initial Evaluation + Treatment (60-75 minutes) --- \$200 for Follow-up Treatments (45 minutes). Rates are subject to change and discounts may not be represented by prices listed above.</p>
	<p><b>MEDICARE PART A/B POLICY:</b> I confirm that I am <b>NOT</b> currently receiving care under <b>Medicare Part A</b>, a home health care/agency, hospice care, or receiving any other services, including but not limited to, Physical Therapy from any other providers. Doing so may risk being covered for my sessions with NLPT and may result in being charged in <b>FULL</b> for sessions not covered by Medicare Part B.</p>
	<p><b>NON-COVERED SESSIONS AND AUTHORIZATION OF CREDIT/DEBIT CARD POLICY:</b> As previously mentioned in Page 1 of this form, <b>patient is responsible for any charges that the insurance does not cover</b> and will be charged <b>at the current cash/card rate</b>. Patient must provide a credit/debit card to ensure payment for any sessions not covered by insurance. Patient also authorizes that No Limit Physical Therapy can charge the card indicated below at any time in the event of non-coverage. <b>A test amount of \$1.00 will be charged</b> after first session to ensure proper information is provided.</p> <p>Name: _____ Card Number: _____          Expiration Date: _____ CVV (3-4 digit): _____ Zip Code: _____</p>
	<p><b>CANCELLATION/NO SHOW POLICY:</b> Please call/text 858-769-6069 or email <a href="mailto:info@nolimitphysicaltherapy.com">info@nolimitphysicaltherapy.com</a> if you need to cancel your appointment. Cancellations have a serious impact especially because it is 1-on-1. Every patient will be allowed <b>ONE</b> free cancellation/no show for the <b>duration of their care. REGARDLESS OF CIRCUMSTANCE</b>, any no shows or cancellations less than 24 hours in advance will be charged a \$100 fee and the patient wholly responsible. Cancellations <b>AFTER</b> work hours are considered late; Please give yourself ample time to contact us at your soonest convenience.</p>
	<p><b>WITHIN 30-MIN SCHEDULED APPOINTMENT POLICY:</b> Due to the nature of In-Home PT, travel times can vary in between patients due to traffic and emergencies may arise during travel, so to best serve our patients, we ask that patients allow up to 30 minutes from their scheduled appointment time to begin the session.</p>

I have read the above information, and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits, and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Guardian



## RELEASE OF LIABILITY

**As a new patient/client of No Limit Physical Therapy I hereby acknowledge and understand the following:**

Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services (collectively "Therapy"). The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related to health and wellness of individuals through the use of physical therapy interventions. Physical therapists are not authorized in California to diagnose disease.

No Limit Physical Therapy does not discriminate and therapy being provided by No Limit Physical Therapy is provided without regard to the patient's race, religion, gender, color, national origin, ancestry, physical handicap, medical condition, marital status, age or sex. Response to therapy treatment varies by individual. Therefore, No Limit Physical Therapy cannot predict my response to therapy. While the goal is improvement of the condition in which I am seeking therapy, I understand that there is a possibility that my condition may worsen and therapy may cause pain, injury and even death. I also understand and acknowledge that I may develop new or different injuries as a result of my participation in a physical therapy program and in receiving Therapy. I also acknowledge

With full knowledge of the above, I hereby knowingly and voluntarily assume any risks associated with the therapy that I receive and I, along with my heirs and assigns, fully and forever release No Limit Physical Therapy, its owners, partners and providers of therapy services from any and all injury which may naturally occur and which are inherent in receiving therapy.

I understand that it is my right to decline to participate in physical therapy in general and specifically any treatment proposed by No Limit Physical Therapy, and that I will immediately notify my physical therapist of any pain, discomfort, dizziness, or any other concern that I may have. I understand that it is my right to ask the physical therapist about my specific treatment plan along with the associated risks and benefits.

I further acknowledge that I have consulted with my physician prior to participating in therapy to determine whether therapy is safe, warranted and recommended and I have been informed that it is. I further acknowledge that I have been advised that I need to fully disclose any medical condition that I have that may affect my therapy and that if I am not sure then to discuss such condition with my physical therapist prior to receiving Therapy.

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Signature of Guardian (if patient is a minor)**

\_\_\_\_\_  
**Date**



## **HIPAA AUTHORIZATION/NOTICE OF INFORMATION PRACTICES**

We understand that health information about you is personal, and we are committed to protecting it. We create a record of the care, services, and assessments you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the health-related records of your care generated by No Limit PT, whether made by your personal treating practitioner or others working within No Limit PT. You acknowledge you have viewed the Notice of Privacy Practices listed below written in plain language, which provides in detail the uses and disclosures of your protected health information, your individual rights, how you may exercise these rights, and No Limit PT's legal duties with respect to your protected health information.

No Limit PT is required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Not retaliate against you for filing a complaint.

I have read and fully understand No Limit Physical Therapy's Notice of Information Practices. I understand that No Limit Physical Therapy 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 notify No Limit Physical Therapy. I also understand that No Limit Physical Therapy will consider requests for restrictions 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 No Limit Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

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**Printed Name of Patient**

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**Signature of Patient**

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**Signature of Guardian (if patient is a minor)**

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**Date**