COASTAL WOUND CARE

PHYSICAL THERAPY, PC

RESTORE • REBUILD • RENEW

NEW PATIENT

Intake Packet

Welcome to Coastal Wound Care and Physical Therapy, PC.

BEFORE YOUR VISIT

Please complete all applicable questions before your first visit.

Enter “N/A” when a question does not apply.

Save the completed form and bring it with you, or call our office for secure electronic return instructions.

PLEASE BRING

- Photo identification
- Insurance cards
- Current medication list
- Physician referral or orders, if applicable
- Any braces, orthoses, prostheses, or assistive devices you currently use

MEDICAL EMERGENCIES

Coastal Wound Care and Physical Therapy, PC does not provide emergency services. For chest pain, difficulty breathing, symptoms of stroke, severe injury, uncontrolled bleeding, or another medical emergency, **call 911** or go to the nearest emergency department.

321 5th St, Floor 1, Hollister, CA 95023-3832 · Phone (831) 281-3328 · Fax (831) 324-6433 · coastalwoundpt.com

SECTION 01

Patient Information

Last name *

First name *

Middle initial

Date of birth (MM/DD/YYYY) *

Sex *

○ Male ○ Female ○ Other

Preferred language *

Primary phone number *

Is this a cell phone? *

○ Yes ○ No

Email address *

Address line 1 *

Address line 2

City *

State *

ZIP code *

Emergency contact

Emergency contact name *

Emergency contact phone number *

Relationship to patient

SECTION 02

Insurance

Insurance company *

Member / policy ID *

Group number

Is the patient the policy holder? *

○ Yes ○ No

If no, policy holder full name

Policy holder date of birth

Relationship to patient

SECTION 03

Primary / Referring Provider

Primary care physician / primary medical provider

Referring provider, if different

Provider phone number

SECTION 04

Physical Therapy Direct Access

When you do not have a referral

California law permits a patient to begin physical therapy treatment without a physician referral. If I am receiving physical therapy through direct access, I understand that treatment may not continue beyond **45 calendar days or 12 visits, whichever occurs first**, unless the physical therapist receives the required approval of the plan of care from an authorized physician or podiatrist.

If, at any time, my physical therapist believes that my condition requires evaluation or treatment beyond the scope of physical therapy, or that I am not progressing appropriately, I may be referred to an appropriate healthcare provider.

If I have a physician, California law requires the physical therapist, **with my written authorization**, to notify that physician that I am receiving physical therapy treatment. **Please note Medicare does not allow for direct access**.

Direct access physician notification authorization

- ○ I **AUTHORIZE** Coastal Wound Care and Physical Therapy, PC to notify my physician that I am receiving physical therapy treatment.
- ○ I **DO NOT AUTHORIZE** notification of my physician
- ○ I do not currently have a physician

SECTION 05

Medical History

Medical conditions

Check all that apply.

- [ ] High blood pressure
- [ ] Heart disease / heart attack
- [ ] Congestive heart failure
- [ ] Peripheral arterial / vascular disease
- [ ] Blood clot / DVT / pulmonary embolism
- [ ] Diabetes
- [ ] Neuropathy / sensory loss
- [ ] Kidney disease / dialysis
- [ ] Liver disease / hepatitis
- [ ] Cancer
- [ ] Autoimmune disease / rheumatoid arthritis
- [ ] Chronic steroid or immunosuppressive treatment
- [ ] Bleeding disorder
- [ ] Anemia
- [ ] Seizure disorder
- [ ] Respiratory disease
- [ ] Stroke / TIA
- [ ] Cognitive impairment
- [ ] Osteoporosis / osteopenia
- [ ] Arthritis
- [ ] Joint replacement
- [ ] Pacemaker, implanted defibrillator, or other implanted electronic device
- [ ] Current or recent pregnancy
- [ ] None

Details for any conditions checked

Other current medical conditions

Prior surgeries and approximate year

Recent hospitalizations, dates, and reasons

Allergies and sensitivities

SECTION 06

Medications

Medications *

- ○ I uploaded/provided my medication list
- ○ I will enter my medications below
- ○ I take no medications

Current medications

High-risk medications *

Check all that apply, or "None."

- [ ] Blood thinner / anticoagulant
- [ ] Antiplatelet medication
- [ ] Prednisone / steroid
- [ ] Chemotherapy
- [ ] Immunosuppressive medication
- [ ] None

SECTION 07

Current Condition

Reason for physical therapy

What is the primary problem or reason you are seeking physical therapy? *

Approximately when did the problem, injury, or symptoms begin? *

Is this a work related injury? *

- ○ Yes
- ○ No

What caused the problem or injury, if known?

Have you had surgery related to this condition? If yes, please list the procedure and date

Have you had X-rays, MRI, CT, ultrasound, or other diagnostic testing for this condition?

Do you currently have any physician-ordered precautions, restrictions, or weight-bearing limitations?

Do you use any assistive devices?

☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis ☐ Other

If other, please describe

What activities are currently most difficult or most important for you to improve?

What are your goals for therapy?

Anything else you would like your clinical team to know?

SECTION 08

Communication Preferences

How would you prefer we contact you?

Check all that apply.

☐ Phone call ☐ Voicemail ☐ Text ☐ Email

SECTION 09

Consent to Evaluation and Treatment

I authorize personnel of Coastal Wound Care and Physical Therapy, PC to evaluate and treat me within their professional scope, training, competency, and my individualized plan of care. Treatment may include, when clinically appropriate, physical therapy examination and functional testing; therapeutic exercise and therapeutic activity; neuromuscular re-education; gait and balance training; transfer training; manual therapy; joint and soft-tissue techniques; edema management; positioning; training with assistive, orthotic, or prosthetic devices; home exercise; self-care and caregiver education; and other appropriate rehabilitation interventions.

Treatment may also include physical agents or rehabilitation technologies when clinically appropriate, including electrical stimulation, therapeutic ultrasound, heat or cold therapy, mechanical traction, or other modalities within the clinician's scope of practice and competency. I understand that treatment may involve temporary discomfort, fatigue, muscle soreness, skin irritation, bruising, dizziness, loss of balance, or other risks depending on my condition and the intervention performed. No cure or specific result is guaranteed.

I may ask questions, refuse any intervention, request additional explanation, or withdraw my consent at any time. The practice may communicate with my referring provider and other professionals involved in my care for treatment, payment, and healthcare operations as permitted by law. I have read and agree to the Consent to Evaluation and Treatment.

I have read and agree to the Consent to Evaluation and Treatment *

- ○ I consent
- ○ I do not consent and elect not to receive treatment

SECTION 10

Authorized Contacts

You may identify people with whom Coastal Wound Care and Physical Therapy, PC may communicate regarding routine scheduling, billing, or care coordination. A separate authorization may still be required for certain medical-record disclosures.

Authorized contact — name and relationship

Contact phone number

What may we discuss with this contact?

- ☐ Scheduling
- ☐ Billing
- ☐ Clinical information

SECTION 11

Telehealth Consent

Telehealth may be used when clinically appropriate for physical therapy consultation, follow-up, education, care coordination, home exercise review, and evaluation by an appropriately licensed clinician. Telehealth may involve video, audio, telephone when permitted, secure messaging, remote monitoring, or electronic exchange of health information. Potential benefits include improved access and faster follow-up. Limitations may include technology failure, privacy or security risks, incomplete information, and the inability to perform a hands-on examination or procedure.

A clinician may stop a telehealth visit or require an in-person examination, diagnostic testing, referral, urgent care, or emergency evaluation when telehealth is not adequate or safe. Telehealth is not an emergency service. I may decline or withdraw telehealth consent at any time and request an in-person visit when available.

Telehealth selection *

- ○ I **CONSENT** to telehealth services.
- ○ I decline telehealth services at this time.

SECTION 12

Text Message (SMS) Consent

I may choose to receive text messages from Coastal Wound Care and Physical Therapy, PC for appointment confirmations, appointment reminders, scheduling, and other non-marketing communications related to my care.

Message frequency may vary. Message and data rates may apply. Standard SMS may not be fully secure. Consent to receive text messages is not a condition of receiving treatment. I may reply STOP to opt out and HELP for assistance.

SMS consent *

- ○ I consent to receive SMS/text messages.
- ○ I do not consent to receive SMS/text messages.

SECTION 13

Home and Community Services

If services are provided outside the clinic, I agree to provide reasonable and safe access to the visit location; secure pets; disclose smoke, weapons, infectious exposure, pests, structural hazards, or other safety concerns; and have necessary equipment or supplies available when instructed.

Staff may pause, end, or reschedule a visit if the environment is unsafe or required care cannot be provided safely.

SECTION 14

Financial Agreement

and Assignment of Benefits

Coastal Wound Care and Physical Therapy, PC will make reasonable efforts to verify insurance benefits and submit claims when it participates with or accepts my coverage. Benefit information, authorization, referral, prescription, or plan-of-care certification does not guarantee payment.

I am responsible for applicable deductibles, copayments, coinsurance, non-covered services, and balances assigned to me by my payer except where prohibited by law or contract.

I assign to Coastal Wound Care and Physical Therapy, PC insurance or health-plan benefits payable for covered services rendered to me to the extent permitted by law and my benefit plan. I authorize the practice to submit claims and supporting documentation and to receive payment directly.

I authorize release of information reasonably necessary to determine benefits, obtain authorization, submit or appeal claims, coordinate benefits, and collect payment.

Amounts known to be due may be collected before or at the visit. Estimates may change after payer processing.

Medicare coverage is dependent upon medical necessity and Medicare requirements. Where permitted, I remain responsible for deductibles, coinsurance, and services Medicare determines are not covered.

Insurance coverage may require a physician referral, prescription, authorization, or plan-of-care certification even when California law permits direct access to physical therapy.

SECTION 15

Missed Appointment

Late cancellation policy

A **$30 missed-appointment or late-cancellation fee** may be charged when you do not attend a scheduled appointment or have not called, texted, or rescheduled **at least 24 hours** before the scheduled start time. This fee applies to initial evaluations as well as follow-up treatments.

This fee is not billed to insurance. The practice may waive the fee for emergencies or circumstances outside your reasonable control.

Late arrival may require a shortened visit or rescheduling when there is insufficient time to provide safe and effective care.

Repeated missed appointments or late cancellations may result in scheduling restrictions or discharge from care after appropriate notice.

For workers' compensation or personal-injury cases, attendance information may be reported to the case manager, payer, or referring provider when permitted or required.

Patients are expected to attend scheduled therapy consistently in order to support progress and continuity of care.

Three cancellations within a one-month period may result in discharge from therapy. A break in treatment of two weeks or longer may also result in discharge after clinical review and appropriate notice.

Patients who wish to resume therapy after discharge may be required to schedule a new evaluation and obtain updated authorization, referral, prescription, or other payer requirements when applicable.

SECTION 16

Patient Responsibilities

I agree to provide complete and accurate health, medication, insurance, and contact information; participate in the agreed plan of care and follow safety instructions; attend scheduled visits or provide timely notice when rescheduling is needed; and promptly inform my clinician about new symptoms, medication changes, hospitalization, new injuries, falls, or other changes that could affect treatment.

SECTION 17

Notice of Privacy Practices

Effective September 1, 2026

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES. This notice explains how medical information about you may be used or shared, how you can access that information, and the privacy rights available to you. Please review it carefully.

Your Privacy Rights

You may ask to inspect or obtain an electronic or paper copy of your medical record and other protected health information we maintain about you. We generally respond within the time required by law and may charge only a reasonable, cost-based fee when permitted.

Amendments. If you believe information in your record is incorrect or incomplete, you may ask us to amend it. We may deny a request in certain circumstances, but if we do, we will explain the reason in writing as required by law.

Confidential communications. You may ask us to contact you in a specific way, such as by mobile phone rather than home phone, or to send mail to an alternate address. We will accommodate reasonable requests.

Restrictions. You may ask us not to use or disclose certain information for treatment, payment, or health care operations. We are not always required to agree. If you pay in full out-of-pocket for a service and ask us not to disclose that service to your health plan for payment or operations, we will honor the request unless disclosure is required by law.

Accounting of disclosures. You may request a list of certain disclosures of your health information made during the six years before your request. The accounting does not include many routine disclosures, such as those for treatment, payment, health care operations, or disclosures you specifically authorized. One accounting in a 12-month period is provided without charge; additional requests may carry a reasonable fee when permitted.

Personal representatives. If another person has legal authority to act for you, such as a guardian or health care agent, we will verify that authority before allowing the person to exercise your privacy rights.

Your Choices

For certain disclosures, you may tell us what you want us to do. For example, you may tell us whether we may share relevant information with family members, friends, caregivers, or others involved in your care or payment for your care. If you are unable to tell us your preference, we may share limited information when permitted by law and when we believe doing so is in your best interest or needed to reduce a serious and imminent threat.

Written authorization is generally required for uses or disclosures of protected health information for marketing when HIPAA requires authorization, the sale of protected health information, and most uses or disclosures of psychotherapy notes. Coastal Wound Care and Physical Therapy, PC does not sell protected health information. We do not use protected health information for fundraising activities.

How We Typically Use or Share Your Health Information

Treatment. We may use and disclose your health information to provide, coordinate, and manage your care. This can include communication with physicians, therapists, nurses, wound care professionals, laboratories, imaging providers, pharmacies, home health agencies, skilled nursing facilities, and other health professionals involved in your treatment.

Payment. We may use and disclose health information to bill for services, obtain payment, verify coverage, obtain required authorizations, coordinate benefits, respond to payer audits, or pursue payment from you or another responsible party.

Health care operations. We may use and disclose health information for activities needed to operate the practice, including quality improvement, staff training, credentialing, compliance, auditing, legal and accounting services, patient safety, information technology, scheduling, customer service, and business planning.

Business associates. We may share information with vendors and service providers that perform services for us and need protected health information to do that work. When required, these organizations must sign agreements requiring them to safeguard your information.

Clinical Photography, Wound Images, and Telehealth

Clinical photographs and wound images created for evaluation, measurement, treatment, documentation, or care coordination are part of your medical record and are protected like other health information. Identifiable photographs will not be used for marketing or other purposes requiring authorization without your written permission. Research or educational uses will follow applicable law and any separate consent or authorization requirements.

Telehealth and electronic communications may involve electronic transmission of health information. We use reasonable administrative, technical, and physical safeguards and approved systems intended to protect privacy and security. We document telehealth encounters in the medical record and limit access to authorized users.

Other Uses and Disclosures Permitted or Required by Law

- Public health and safety activities, such as reporting certain diseases, adverse events, abuse or neglect, or preventing a serious threat to health or safety.
- Health oversight activities, including audits, investigations, inspections, licensure, and government program oversight authorized by law.
- Workers' compensation and similar programs when disclosure is authorized or required by law.
- Law enforcement or other government requests when the legal requirements for disclosure are met.
- Court or administrative proceedings, including responses to qualifying orders, subpoenas, or other lawful process.
- Coroners, medical examiners, funeral directors, and organ or tissue donation organizations when permitted by law.
- Research when permitted by law, including with your authorization, an approved waiver, or use of de-identified or otherwise legally permitted information.
- Other disclosures required by federal or California law, including disclosures to the U.S. Department of Health and Human Services for HIPAA compliance reviews.

Substance Use Disorder Records

If we receive or maintain patient records that are protected by 42 CFR Part 2, those records receive additional federal confidentiality protections. Part 2 records generally may not be used or disclosed in a civil, criminal, administrative, or legislative investigation or proceeding against you unless you provide written consent or the disclosure is authorized by the required court order and subpoena. We will apply Part 2 protections when they apply to information in our possession.

California and Other More Protective Privacy Laws

California law may provide additional protections for certain medical information, including some mental health, substance use disorder, HIV/AIDS, genetic, minor-consent, and other specially protected information. When California law or another applicable law provides greater privacy protection than HIPAA, we will follow the more protective requirement.

Our Responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We use administrative, physical, and technical safeguards appropriate to our practice and the systems we use.
- We will notify affected individuals as required by law if a breach occurs that may have compromised the privacy or security of their information.
- We must follow the privacy practices described in the notice currently in effect.
- We will not use or disclose your information for purposes not described in this notice unless you authorize us in writing or another law permits or requires the use or disclosure. You may revoke an authorization in writing, subject to legal limitations and actions already taken in reliance on it.

Changes to This Notice

We may change the terms of this notice and make the revised notice effective for all protected health information we maintain, including information created or received before the change. The current notice will be available upon request, at our office, and on our website when applicable.

Questions, Requests, and Complaints

If you have questions about this notice, want to exercise a privacy right, or believe your privacy rights have been violated, contact our Privacy Officer:

> **Peter Bartges, PT, DPT** — Privacy Officer
> Coastal Wound Care and Physical Therapy, PC
> 321 5th St, Floor 1, Hollister, CA 95023-3832
> Phone: (831) 281-3328 | Fax: (831) 324-6433
> Email: Peter@coastalwoundpt.com
> Website: coastalwoundpt.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201; telephone 1-877-696-6775; or through the HHS Office for Civil Rights complaint website. We will not retaliate against you for filing a complaint with us or with HHS.

SECTION 18

Final Acknowledgment

Signature

By signing below, I certify that the information I provided is accurate to the best of my knowledge. I confirm that I have read, understood, and agree to the applicable Consent to Evaluation and Treatment, Clinical Wound Photography provisions, telehealth selection and consent when selected, communication preferences, home/community visit conditions when applicable, Financial Agreement and Assignment of Benefits, Attendance Policy, Patient Responsibilities, and Notice of Privacy Practices acknowledgment. Please contact our clinic with any questions while completing this intake packet (831) 281-3328.

I have had an opportunity to ask questions. **I intend my electronic signature to serve as my legal signature on this intake packet.**

Printed name *

Date *

I am signing as: *

- ○ Patient
- ○ Parent / guardian
- ○ Legally authorized representative

Relationship / authority if not patient

Signature *

Type your full legal name above to sign electronically, or use your PDF app's "Fill & Sign" tool to draw your signature.

FOR OFFICE USE ONLY

Received by

Date received

Entered in EMR by

- ☐ Photo ID copied
- ☐ Insurance cards copied
- ☐ Referral / orders on file
- ☐ Medication list on file