TheraSens, Inc.

1900 Garden Road, Suite 200 Monterey, CA 93940 PHONE: (831) 250-6770 FAX: (831) 250-6767

Patient Information

(PLEASE PRINT AND FILL OUT ENTIRELY)

TODAYS' DATE_____ PATIENT SOCIAL SECURITY #_____-_____-_____ SEX:F__ M__ NB___

PATIENT'S NAME_____ DATE OF BIRTH_____
LAST MI FIRST

PATIENT'S PRIMARY PHYSICIAN: _____
ADDRESS:_____

PHYSICIAN PHONE: ( ) _____ FAX ( ) _____

OTHER SPECIALTY PHYSICIANS: (please name) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (list): _____

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

WHO REFERRED YOU TO THERASENS OCCUPATIONAL THERAPY_____

EMAIL ADDRESS_____ CELL PHONE ( ) _____

MAILING ADDRESS_____
STREET/ PO BOX CITY STATE ZIP

EMPLOYER_____ PHONE ( ) _____

BUSINESS ADDRESS_____

SPOUSE NAME _____ PHONE ( ) _____ DOB:_____

BUSINESS ADDRESS_____

PATIENT INSURANCE:_____

(PLEASE PROVIDE COPY OF INSURANCE CARD; SEE BOTTOM OF PAGE)

RELATIVE OR FRIEND WE MAY CONTACT IN AN EMERGENCY: _____

NAME
_____ PHONE ( ) _____ CELL ( ) _____
ADDRESS

A COPY WILL BE MADE OF YOUR INSURANCE CARD IF YOU HAVE INSURANCE FOR WHICH WE ARE A PROVIDER OR WHICH WE MAY BILL. CO-PAYS ARE DUE PRIOR TO TREATMENT. FULL PAYMENT IS DUE PRIOR TO TREATMENT IF YOUR INSURANCE WILL NOT BE UTILIZED. IT IS YOUR RESPONSIBILITY TO CONACT YOUR INSURANCE TO DETERMINE COVERAGE.
PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT

SIGNATURE OF PERSON RESPONSIBLE_____

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CANCELLATION POLICY

To avoid charges please notify us if you are unable to attend your therapy visit at least **24 hours prior** to your scheduled visit by calling 831-250-6770. For the first missed appointment or cancellation within 24 hours of your scheduled appointment you will be personally charged a fee of $50. You will be charged for each missed appointment. IF you have 2 "no shows" or last-minute cancellations, you will be removed from the schedule. By signing below, you are agreeing to these terms and conditions.

Signature: _____ Date:_____

AUTHORIZATION FOR APPOINTMENT REMINDER

By signing below indicates that you approve being contacted for appointment reminders by:

____ Email
____ Text

Signature: _____ Date: _____

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Assumption of Risk, Waiver of Liability, Medical Authorization

Patient's Name _____

Phone Number _____ Cell Number _____ Work Number _____

Address _____

Street City State Zip

Emergency Contact (other than yourself) _____

Phone Number _____ Cell Number _____ Work Number _____

I recognize that potentially severe injuries, including but not limited to permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to gymnastics, tumbling, trampoline, stairs, dance, rock climbing, swinging and running. Being fully aware of these dangers, I voluntarily consent to the aforementioned person(s) participating in any and all Therasens, Inc. programs and activities, and I KNOWINGLY ACCEPT FULL RESPONSIBILITY AND ASSUME ALL RISKS associated with that participation. In consideration for allowing the above mentioned person(s) to obtain Occupational Therapy instruction, I, on my own behalf and the behalf of the above mentioned person(s) and our respective heirs, administrators, executors, and successors, hereby COVENANT NOT TO SUE or TRY TO COLLECT DAMAGES IN ANYWAY and FOREVER RELEASE Natalie Sanders personally and Therasens, Inc., its officers, directors, shareholders, employees, contractors, or agents from all liability for any and all damages or injuries suffered by the above mentioned person(s) while under instruction, supervision or control of Therasens, Inc., including without limitation, those damages or injuries resulting from acts of negligence on the part of its officers, directors, shareholders, employees, agents, or Natalie Sanders. I agree to INDEMNIFY AND HOLD such individuals HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of such participation in Therasens Inc. programs and activities and to reimburse them for any such expenses incurred. I expressly acknowledge and agree that this agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. In the event of an emergency, I would like the above mentioned person(s) to be taken to a hospital for medical treatment and I hold Therasens, Inc., Natalie Sanders and its representatives harmless in their execution of this action. Additionally, I herby agree to individually provide for all possible future medical expenses which maybe incurred by my child as a result of any injury sustained while participating in Therasens, Inc. I have read and understand this ASSUMPTION OF RISK, WAIVER OF LIABILITY and MEDICAL AUTHORIZATION and I VOLUNTARILY affix my name in this agreement.

Patient/Legal Guardian Signature _____ Date _____