



BACK 2 HEALTH PHYSICAL THERAPY
& AQUATIC REHABILITATION
PATIENT INFORMATION FORM

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____

MAILING ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ SEX (please circle): MALE FEMALE

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

OCCUPATION: _____

EMERGENCY CONTACT INFORMATION

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY? _____

RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT NUMBER: _____

REFERRING/PRIMARY CARE PHYSICIAN INFORMATION

NAME OF REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN PHONE NUMBER: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

PRIMARY CARE PHYSICIAN PHONE NUMBER: _____

CANCELLATION NOTICE:

PATIENT CARE IS OUR NUMBER ONE PRIORITY, AND WE WILL MAKE EVERY EFFORT TO ACCOMODATE YOUR SCHEDULE. WE UNDERSTAND THAT THERE ARE TIMES WHEN YOU MUST MISS AN APPOINTMENT DUE TO EMERGENCIES OR OBLIGATIONS FOR WORK OR FAMILY. WE REQUEST THAT YOU CONTACT OUR OFFICE WITHIN THE 24-HOURS PRIOR TO YOUR APPOINTMENT IN THE EVENT THAT YOU NEED TO RESCHEDULE. IF YOU MISS AN APPOINTMENT AND DO NOT CONTACT US IN ADVANCE YOU MAY BE CHARGED FOR THE VISIT. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE APPOINTMENT CANCELLATION POLICY AND AGREE TO BE BOUND BY ITS TERMS.

SIGNATURE: _____ DATE: _____



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MEDICAL HISTORY FORM

MEDICAL HISTORY INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____

NATURE OF SYMPTOMS:

1. CHIEF COMPLAINT: _____

2. RATE THE SEVERITY OF YOUR SYMPTOMS AT PRESENT TIME (please rate by circling the appropriate number):

No Pain ---> 0 1 2 3 4 5 6 7 8 9 10 <--- Worst pain you've ever had

3. WHEN DID YOUR PAIN BEGIN (please provide date): _____

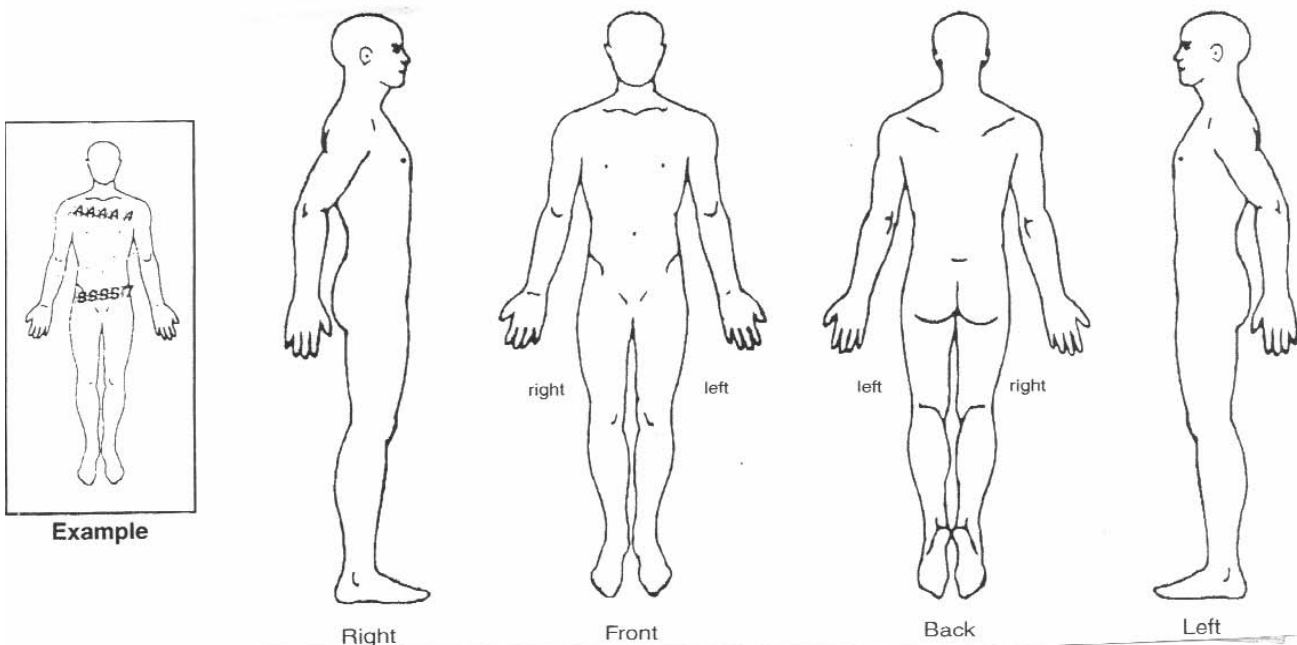
4. WHERE AND HOW DID IT BEGIN (activity and specific cause):

BEHAVIOR OF SYMPTOMS:

5. FUNCTIONALLY, WHAT ACTIVITIES ARE DIFFICULT TO DO BECAUSE OF YOUR PROBLEM (i.e. vacuuming, brushing hair, climbing stairs, etc): _____

LOCATION OF PAIN:

6. PLEASE MARK THE AREAS ON THE BODY DIAGRAM BELOW THAT REPRESENT THE LOCATION OF YOUR SYMPTOMS:





MEDICAL HISTORY FORM

MEDICAL HISTORY INFORMATION (cont'd)

PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING NON-PRESCRIPTION): _____

PLEASE CIRCLE IF YOU HAVE **OR** HAVE HAD ANY OF THE FOLLOWING:

- | | |
|-------------------------|-------------------------------------|
| 1. HEART DISEASE | 14. UNEXPLAINED WEIGHTLOSS |
| 2. STROKE | 15. DEPRESSION |
| 3. RESPIRATORY PROBLEMS | 16. NAUSEA/VOMITING |
| 4. DIABETES | 17. NUMBNESS |
| 5. ARTHRITIS | 18. WEAKNESS |
| 6. ALLERGIES | 19. FAINTING |
| 7. HIGH BLOOD PRESSURE | 20. DIZZINESS |
| 8. FEVER/CHILLS/SWEATS | 21. NIGHT PAIN |
| 9. CANCER | 22. SMOKING AND/OR SUBSTANCE ABUSE |
| 10. MENTAL ILLNESS | 23. CHANGES IN BOWEL/BLADDER HABITS |
| 11. HIV/AIDS | 24. CHANGES IN EATING PATTERN |
| 12. SEXUAL DIFFICULTY | 25. CHANGES IN SLEEPING PATRTERN |
| 13. SHORTNESS OF BREATH | |

PLEASE INCLUDE ADDITIONAL INFORMATION ABOUT CIRCLED ITEMS FOR CLARIFICATION:

HAVE YOU EVER HAD SURGERY? IF YES, PLEASE LIST ALL SURGERIES AND DATES:



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CONSENT FORM

THE FOLLOWING IS A LIST OF MODALITIES AND PROCEDURES USED IN PHYSICAL THERAPY. YOUR PHYSICAL THERAPIST WILL EXPLAIN WHICH ONES WILL BE USED DURING YOUR TREATMENT, DISCUSS TREATMENT ALTERNATIVES, AND GOALS OF TREATMENT WITH YOU.

EVALUATION
ULTRASOUND
ELECTRICAL STIMULATION
MASSAGE AND MUSCLE RELEASE TECHNIQUES TRACTION
POSTURAL TRAINING
BODY MECHANICS, ACTIVITIES OF DAILY LIVING

JOINT MOBILIZATION
JOINT MANIPULATION
MUSCLE STRETCHING
THERAPEUTIC EXERCISE
FUNCTIONAL TRAINING

DURING YOUR PHYSICAL THERAPY IT IS OFTEN NECESSARY TO EXPOSE OR TOUCH THE AREA TO BE TREATED. EVERY EFFORT IS MADE TO PRESERVE MODESTY AND KEEP YOU COMFORTABLE. OUR OFFICE EMPLOYS BOTH MALE AND FEMALE THERAPISTS. PLEASE COMMUNICATE WITH OUR OFFICE STAFF IF THE GENDER OF YOUR THERAPIST IS IMPORTANT TO YOU. IN ADDITION, **BACK 2 HEALTH PHYSICAL THERAPY** EMPLOYS A POLICY THAT THERE MUST BE A CHAPERONE IN THE PRIVATE ROOMS AT ALL TIMES WHETHER THE PATIENT IS MALE OR FEMALE.

COMMENTS:

CONSENT FOR TREATMENT

I GIVE MY CONSENT FOR TREATMENT BY THE HEALTHCARE PROFESSIONAL STAFF OF **BACK 2 HEALTH PHYSICAL THERAPY** TO PROVIDE PHYSICAL THERAPY AND REHABILITATION SERVICES AND NECESSARY TREATMENT AS PRESCRIBED BY MY PHYSICIAN. I UNDERSTAND THAT TO EVALUATE AND TREAT MY CONDITION, THE PHYSICAL THERAPY STAFF MUST HAVE VISUAL OR PHYSICAL ACCESS TO THE AREAS OF MY BODY WHICH MAY BE EXPERIENCING AND/OR CAUSING MY PAIN AND/OR DYSFUNCTION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY COMMUNICATE ANY DIFFICULTIES OR CONCERNS THAT I HAVE REGARDING MY THERAPY TO THE STAFF OF **BACK 2 HEALTH PHYSICAL THERAPY**. I FURTHER UNDERSTAND THAT MY PHYSICIAN SHALL BE KEPT INFORMED REGARDING MY CURRENT HEALTH STATUS AND MY RESPONSE TO ANY TREATMENT RECEIVED. AS WITH ANY COURSE OF TREATMENT OR THERAPY, THERE IS ALWAYS THE POSSIBILITY OF AN UNEXPECTED COMPLICATION AND NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS OF TREATMENT.

PATIENT SIGNATURE: _____ DATE: _____

THERAPIST SIGNATURE: _____ DATE: _____



BACK 2 HEALTH PHYSICAL THERAPY & AQUATIC REHABILITATION

INSURANCE AND BILLING POLICY

As a courtesy, **Back 2 Health Physical Therapy** will submit all claims for services rendered to your medical insurance company. Our staff has already contacted your insurance company regarding your physical therapy coverage. The information given to us by your insurance company does not guarantee payment, it is only a quote of benefits. In order to receive benefits, the member must be covered at the time of service. All claims are subject to medical review according to the information according to the information submitted by the provider of service and are subject to benefit maximums and other terms in the member's contract.

You will receive services today with the understanding that in the event your coverage is not effective at the time of service you will be billed and held financially responsible for these services. Additionally, you agree to be held financially responsible for services provided that are not a covered benefit of your insurance plan.

FINANCIAL ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to **Back 2 Health Physical Therapy** all medical payments and benefits otherwise payable to me for services rendered. I hereby authorize release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that if, for any reason, my insurance does not pay for the treatment I receive from **Back 2 Health Physical Therapy** that I am financially responsible for the denied services. In the event that **Back 2 Health Physical Therapy** arranges a payment plan at the start of treatment, and I discontinue treatment before the end of the plan term, I will be held financially responsible for all services rendered by **Back 2 Health Physical Therapy**, and it will be billed in full for these services. **I understand that the cash price for services at Back 2 Health Physical Therapy are as follows: \$165.00 for evaluation and \$100.00 for physical therapy visits thereafter.**

****Please note that if you have a financial hardship we will try to work out a payment plan that is better for you. Please see our office manager regarding this.**

I HAVE READ THE ABOVE AND UNDERSTAND THE POTENTIAL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED DURING THE CURRENT CALENDAR YEAR AND HEREBY AFFIX MY SIGNATURE IN ACKNOWLEDGEMENT OF THIS UNDERSTANDING. I ALSO HEREBY ACKNOWLEDGE THAT I COMPLETELY AND FULLY UNDERSTAND THE ABOVE. IF I DO NOT FULLY UNDERSTAND ENGLISH, I ACKNOWLEDGE THAT THIS INFORMATION HAS BEEN ADEQUATELY TRANSLATED TO ME.

PATIENT'S SIGNATURE: _____ DATE: _____

PRINTED NAME OF PATIENT: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we describe below, we will not sell your health information or provide any of your health information to any outside marketing company.

Uses and Disclosures

Below you will find examples of how we may have to use or disclose your health care information:

1. Your doctor or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
3. It may be necessary for the doctor and members of the staff to use your health information, examination, and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your doctor and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

As our patient, you possess the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency or disaster relief situation.
3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. If we are provide health care services to you as a result of a Workers' Compensation injury.
5. If you are/ were a member of the armed forces, we are required by military command authorities to release your health information.
6. If we provide health care services to you as an inmate.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the above examples, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke (take away) your privacy release authorization from us at any time; however, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address listed below. There are two circumstances under which we will not be able to honor your revocation request.

1. If we have already released your health information before we received your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

Back 2 Health Physical Therapy and Aquatic Therapy
9201 W. Sunset Blvd Suite M120
West Hollywood, CA 90069

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and /or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and / or copy your health information be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you and accounting if the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- Those disclosures made for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPAA privacy law.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem

If you believe your privacy rights have been violated, you can either file a complaint with this office, or with the office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office is as follows:

California Department of Public Health
Office of Civil Rights, MS 0504
P. O. Box 997377
Sacramento, CA 95899-7377

Voice: (916) 445-0938
TTY: 711
Fax: (916) 323-5499

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of (Date). This authorization will expire seven years after the date in which you last received services from us.

Patient Name Printed

Date

Patient Signature