Pro-Health Physical Therapy Inc.
2850 Artesia Blvd. Suite 207, Redondo Beach, CA 90278
Tel. (310) 371-4774 Fax (310) 371-3453
www.Pro-HealthClinic.com

Patient Information

Last Name _____ First Name _____ Sex _____ Age _____

Date of Birth _____ SS# _____ - _____ - _____ Driver's License _____

Address: _____ City: _____ State: _____ Zip Code: _____

Mobile# (_____) _____ Home# (_____) _____ Work# (_____) _____ Main# Click on preferred contact Mobile Hm Wk

Email: _____ Who can we thank for referring you? _____

Emergency Contact _____ Relationship _____ Phone# (_____) _____

Insured or Responsible Party: _____ Relation: _____ DOB: _____ SS#: _____

Do you require language assistance? Yes ☐ No ☐ Language spoken: _____ Do you have a prescription for Physical Therapy YES ☐ NO ☐
Click next to YES or NO

Are you a returning patient? Yes ☐ No ☐ Where you referred by a Physician? Yes ☐ No ☐
Click next to YES or NO Click next to YES or NO

Referring Physician's Name _____ Primary Physician's Name _____

Billing Information *Must complete this section if this is due to a work comp or personal injury accident*

Insurance Company _____ ID# _____ Group# _____

Is your injury work related? YES ☐ NO ☐ Claim# _____ Work Comp Company _____
Click next to YES or NO

Is your injury related to an accident? Auto? YES ☐ Other?YES ☐ NO ☐ Date of accident _____
Click YES Click Nect to YES or NO

Are you involved in a lawsuit as a result of this injury? YES ☐ NO ☐ Are you using AutoMedPay or Homeowners insurance? YES ☐ NO ☐
Click next to YES or NO Click next to YES or NO

Are you working with an attorney? Name _____ Phone# (_____) _____

Billing Policy

We are happy to help you with your insurance questions and will verify your insurance coverage as a courtesy. It is however your responsibility to verify your plan's coverage for physical. Some insurance companies require pre-authorization for treatment, have a visit maximum per year or have reimbursement limits on physical therapy treatments; it is ultimately your responsibility to know and meet the requirements of your insurance plan. We will give you a copy of the coverage and benefits we receive from your insurance upon request.

Most insurance policies have a deductible and require a copayment/coinsurance for each visit. Consequently, it is your responsibility as defined by your policy to pay the deductible/copayment/coinsurance at the time of service. You will be billed and be responsible for the cost of treatments in the event of non-reimbursement by your insurance plan due to deductible or denial of your claims.

Some supplies, such as Electrodes, braces, pillows, exercise equipment, taping, etc. can be purchased at our clinic. We will not bill insurance for supplies but you may submit your receipts to your insurance company if you wish to try to seek reimbursement.

Physical therapy is an ongoing process which requires regular attendance to be optimally effective. You can discuss any issues of financial hardship with our office manager for financial assistance or payment plan; and discuss such issues with your therapist so that therapy attendance/frequency can be accommodating of your needs.

Date _____ Signature of Patient or Responsible Party _____
I understand and agree to the above billing policy

Financial Agreement - Authorization to Release Information and Assignment of Benefits

I authorize Pro-Health Physical Therapy, Inc. (thereafter referred to as "Pro-Health") to bill my insurance company directly for services rendered to myself or my dependents and authorization for payment to be made directly to Pro-Health. In the event that my insurance company forwards payment directly to me, I will immediately deliver such payment to Pro-Health.
I authorize Pro-Health to furnish my insurance company with full medical or other information necessary to process my claims.
I understand that my insurance is billed as a courtesy and that I am ultimately responsible for all charges not paid by my insurance, including deductible, co-insurance, co-payment, or any charges denied or not covered by my insurance carrier.
I understand that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any legal costs and or court fees. I understand that I am financially responsible for any and all services rendered to me or my dependents at Pro-Health.

Date _____ Signature of Patient or Responsible Party _____
As the Patient/Responsible party, I understand and agree to the above financial agreement

Cancellation / No-Show Policy

Out of fairness to all patients on our wait lists, we try to limit last minute cancellations or no-shows with our automated appointment reminder service. Each same day cancellation or no-show **will incur a fee of $25.00** (billed to the patient). After the **3rd same day cancellation or no-show you will be charged the current visit cash rate of $85** or placed on a same day schedule policy and will not be able to schedule out appointments ahead of time. We ask that you kindly give at least one day notice in advance of any appointment rescheduling or cancellation so that you can avoid the fee and we can have time to call our wait list to fill the appointment. **To avoid a fee,** you can call or email us during business hours or leave a message on our voice mail or email us no later than 8am the day of your appointment. We appreciate you as our patient and thank you for your understanding.

Please √ Preferred choice for automated appointment reminders and the authorized phone # or email address for these notifications

◯ **Voice** ◯ **Text** ◯ **Email** **Phone # or Email:** _____

Date _____ Signature of Patient or Responsible Party _____
I understand the above cancellation policy

Informed Consent for Physical Therapy Treatment

Physical therapy services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnostic impression, prognosis and intervention including hands-on manual therapy, exercises, and physical agents to minimize discomfort, facilitate convalescence and optimize functional recovery.

As defined in Section 2620 of the Business and Professions Code: "*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".*

The physical therapist will inform you of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care; and will also explain the risks of receiving no treatment. All procedures will be thoroughly explained to you. It is your right to decline any part of your treatment should you feel any discomfort or have other unresolved concerns. It is your right to ask your physical therapist about the treatment plan and discuss the potential risks and benefits involved in your treatment. It is also your right to ask about treatment alternatives.

Since the response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain treatment modality or procedure. In the same way, we are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee the outcome of our care or to what extent our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or, although unlikely, may cause injury or aggravate previously existing conditions. Since therapeutic exercises are an integral part of most treatment plans, exercising will bring inherent physical risks to the care received at Pro-Health Physical Therapy, Inc.
I understand that any pre-existing medical conditions, my overall health status, as well as my participation and compliance with the established plan of care may influence the outcome of my care received at Pro-Health Physical Therapy, Inc.

I understand the risks associated with physical therapy and was given the opportunity to ask any questions and clarify any of my concerns. I thus wish to proceed and hereby consent to evaluation and treatment of my condition by any physical therapist (and/or assistant/aid rendering treatment under the supervision of the physical therapist) who are employed or working for Pro-Health Physical Therapy, Inc.

Date _____ Signature of Patient or Responsible Party _____
I consent to Physical Therapy at Pro-Health Physical Therapy

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Intake Form

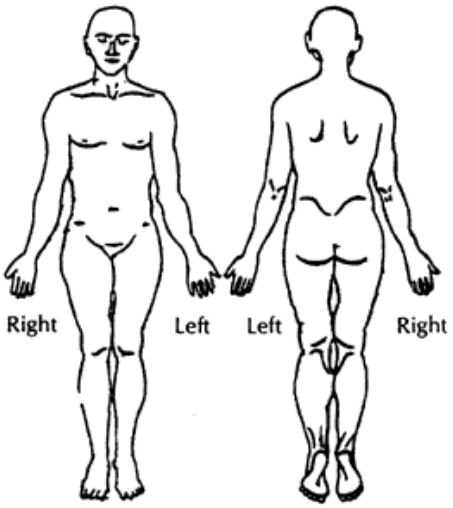
Last Name _____ First Name _____ Date _____

DOB _____ Age _____ Sex _____ Height _____ Weight _____ Dominant Hand: Right / Left
Click on Right or Left

Reason for visit/describe your symptoms _____

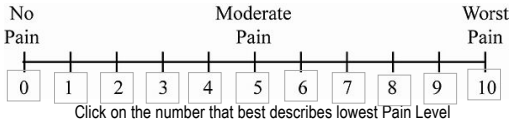
_____

Where are your symptoms? Indicate on the body chart.
Mark Pain X Numbness O Tingling Z

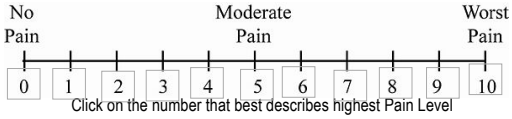


Where is your ***main/most severe*** pain

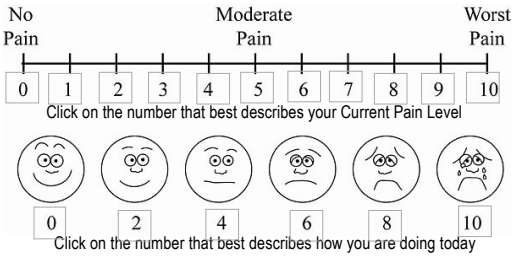
In the last week, including at rest, what was your LOWEST pain level?



In the last week, including with activity, what was your HIGHEST pain level?



What is pain level NOW?



Indicate the nature of your "main/most severe" pain and symptoms: ☐Constant ☐Intermittent (on/off) ☐Always there but fluctuating in intensity

☐Sharp ☐Dull ☐Shooting ☐Aching ☐Throbbing ☐Deep ☐Superficial ☐Tingling ☐Numbness ☐Burning ☐Stabbing _____

Date of Injury _____

How did this problem begin?_____

_____

What makes your symptoms/pain worse?_____

What makes your symptoms/pain lessen?_____

Are your symptoms worse in the: ☐Morning ☐Afternoon ☐Evening ☐ During night ☐Always same ☐ Inconsistent

Are your symptoms: ☐Improving ☐ Getting worse ☐Stable

Have you ever had such symptoms in the past? Yes / No
Click YES or NO

Please describe any previous treatment and response to care

_____

_____

Medical History

Are you pregnant? Yes ☐ No ☐ Trying to get pregnant? Yes ☐ NO ☐ Do you have osteoporosis? Yes ☐ No ☐ Date of last bone scan: _____
Click on YES or NO

Have you ever been diagnosed with the following conditions? Click on the box next to the diagnosed condition

☐ Cancer; if yes describe: _____

☐ Heart problems	☐ High Blood Pressure	☐ Circulation problems	☐ Asthma	☐ Emphysema / Chronic bronchitis
☐ Thyroid problems	☐ Diabetes	☐ Rheumatoid arthritis	☐ Lupus	☐ Multiple sclerosis
☐ Epilepsy	☐ Anemia	☐ Kidney disease	☐ Stroke	☐ Tuberculosis
☐ Hepatitis	☐ Depression	☐ Other arthritic conditions	☐Anorexia/Bulimia	☐ Bruising or bleeding disorders

☐ Chemical dependency (alcohol, drugs, medications) Do you have: ☐Metal or ☐Other implants? Do you have intolerance to: ☐ Hot ☐ Cold?

Explain any above:_____

Have you recently noted or experienced? Click on the box next to the symptoms you have experienced

☐ Unintentional weight loss/gain	☐ Over 15 lbs of intentional weight loss	☐ Fever / chills / sweats	☐ Nausea/vomiting
☐ Loss of appetite	☐ Severe/worsening night pain	☐ Severe or constant headaches	☐ Progressive weakness
☐ Progressive weakness	☐ Change in bladder or bladder functions	☐ Memory loss	☐ Fatigue
☐ Shortness of breath	☐ Symptoms change with coughing / sneezing	☐ Decreased exercise tolerance	☐ Loss of sensation
☐ Numbness / Tingling	☐ Dizziness / vertigo / lightheadedness	☐ Change in balance / falls	☐ Fainting
☐ Skin changes / palpable mass	☐ Changes in your speech / swallowing	☐ Changes in your vision	☐ Ringing in the ear

Does anyone in your immediate family (mother, father, siblings) have a history of: ☐Diabetes, ☐ High Blood Pressure, ☐Cardiac Problems, ☐Cancer?

Explain any above:_____

Have you ever had previous neck, back or joint injuries? _____

List any other illness or past injuries we should be aware of?_____

List surgeries (mention year and if any complications): _____

Medications, Allergies and Diagnostic Tests

Are you taking any medications for your present symptoms/pain? Yes ☐ No ☐ ☐ A list of medication was provided **OR** Please list:
Click on YES or NO

_____

Are you taking any other medications? Yes ☐ No ☐ ☐ A list of medication was provided **OR** Please list:
Click on YES or NO

_____

Do you have any allergies? Yes ☐ No ☐ Please list:_____
Click on YES or NO

Have you undergone any special tests for the condition for which you are seeing us? (X-rays, MRI's, etc.) Yes ☐ No ☐
Click on YES or NO

*If yes do you have copies of the report or know the results?*_____

FUNCTIONAL LEVEL

Do you use any assistive devise? (i.e. cane, brace, foot orthotics)_____

Has this condition affected your daily ? Yes ☐ No ☐ Explain:_____
Click on YES or NO

Are you presently working? Yes ☐ No ☐ ☐ Full-time ☐ Part-time Is your work limited by your condition? Yes ☐ NO ☐

Please Explain_____

Overall normal activity level (when not symptomatic/injured): ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy ☐ Competitive

Normal/regular sports and exercise (Type, Frequency, Duration)_____

Has this condition affected your normal activity level? Yes ☐ NO ☐ *Please Explain:* _____

_____

PRO-HEALTH
PHYSICAL THERAPY

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Acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES (HIPAA)

I have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I was allowed to review the document and/or obtain a take-home printed copy.

Date _____ Signature of Patient or Responsible Party _____

IN SUMMARY…

Your health information will be used or shared

- **To treat you**: We can use your health information and share it with other professionals who are treating you.
- **To run our organization**: We may contact you (phone and/or email) when necessary to schedule or change an appointment; to follow-up on a treatment/service provided; and/or to discuss tests results or plan of care. You can request appointment reminders via email. You may receive communications from our office (mail and/or email) such as copied records, statements, holiday/get-well cards, or special events that occur at this office.
- **To bill for your services**: We can use and share your health information to get payment from health plans or other entities.
- We will NEVER sell your information. We will not use your information for marketing purposes (i.e. testimonials, pictures) without your written permission.

How else can we use or share your health information?

- Help with public health and safety issues: helping with product recalls; reporting suspected abuse, neglect, or domestic violence; or preventing or reducing a serious threat to anyone's health or safety.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.
- Comply with the law.

Your Rights and Privileges:

Right to review or copy your medical record: You can ask in writing to see or get a copy (electronic or paper) of your medical record. We will comply within 30 days of your request and may charge a reasonable, cost-based fee. **Right to amend your medical record:** You can request an amendment in writing to your record if you feel that your health information is incorrect or incomplete. If we disagree and will not change the information; we will tell you why in writing within 60 days. **Right to request confidential communications:** You can request in writing that we contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will oblige all reasonable requests. **Right to restrict sharing of information:** You can request in writing for us not to use/share certain health information for treatment, payment, or our operations. We are not required to agree to your request if it would affect your care. **Right to accounting of disclosures:** You can ask for a list of the times we've shared your health information who we shared it with, and why; except for those about treatment, payment, and health care operations. **Right to a copy of this privacy notice:** You can ask for a paper copy of this notice at any time. **Right to choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. **Right to file a complaint:** You can complain if you feel we have violated your rights by contacting us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

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NOTICE OF PRIVACY PRACTICLES (HIPAA)

Please review this information carefully about your privacy rights

It Advises You of Your Medical Privacy Rights and How You Can Access Your Records

We are committed to maintaining the privacy of your medical records, (PHI). We are also required by law to provide you with this information. PHI includes information about your health condition and the care and treatment you receive from this Office. PHI is your Personal Health Information or medical chart.

How We Use and Disclose Your PHI

As outlined in this **NOTICE** we are allowed to use and disclose your PHI for the purposes of Treatment, Payment, and Health Care Operations, (**TPO**), and may do so without your express consent or authorization:

Treatment. We will use and/or disclose your PHI to others to manage your treatment. This may be necessary to provide you the healthcare you need.

Payment. We will use your PHI to obtain payment for the treatment we provided to you. This usually means your insurance company or health plans. It may include all persons or entities responsible for the payment of your bills at this office.

Health Care Operations. To comply with legal and insurance requirements we may have to disclose all or parts of your PHI. We may disclose PHI to provide you with quality and timely treatment.

Additional Ways Your PHI Can Be Used

Appointment Book and Sign-In Sheet – The appointment book helps us organize our patient visits. The sign-in sheet records the patients that arrived for their appointment. It is possible others will see your name on these documents.

Appointment Reminders – We may remind our patients of their appointments or missed appointments. The reminder may be by telephone or email. We will use the current email address and telephone number that you have given us.

Disclosures to Others. Others may include family members and other members of your household. You may also name others.

Additional Uses and Disclosures of PHI Permitted or Required by Law

We may also use and/or disclose your PHI, without your consent or authorization in the following ways:

PHI that is De-identified. We can use and disclose your medical information if it does not identify you.

Use and/or Disclosure to Business Associates. We may use disclose your PHI to business associates. Business associates are people or companies that work with us. This will only be done if they have provided us with written assurances that they will properly protect your PHI.

Disclosure to Your Personal Representative. We may disclose your PHI to a person who is designated by law as your personal representative.

In Emergency Situations. We may use and/or disclose your PHI for emergency treatment. We will try to get your consent as soon thereafter as possible.

Activities Related to Public Health and Welfare. We may use and/or disclose your PHI when the law requires us to provide information. This may be to public health authorities to prevent and/or control disease.

Evidence of Domestic Violence, Child or Elder Abuse or Neglect Are Present. We may use and/or disclose PHI when allowed by or compelled by law. This may be to provide information to prevent serious injury or harm.

Criminal or Regulatory Activities. We may disclose PHI when allowed by or compelled by law. This may be for a criminal investigation.

Legal Proceedings. We may use and/or disclose PHI in response to a court order or lawfully issued subpoena.

Disclosures to Law Enforcement Agencies. We may disclose PHI when allowed by or compelled by law to a law enforcement agency or official. This may include the coroner or medical examiner.

Threat to Public Health and Safety. We may use and/or disclose PHI if we have a good faith belief that the disclosure is necessary to prevent or lessen a serious and/or imminent threat to the public health, safety, and welfare. The disclosure will be to an individual or entity that is reasonably able to prevent or substantially lessen the threat.

Workers' Compensation Claim. We may use and/or disclose PHI of patients that have a workers' compensation claim. The disclosure will be to your workers' compensation payer. This may apply to other claims under state law.

Disclosures Pursuant to Your Authorization

Except for the disclosures set forth above we will only disclose your PHI as outlined in your written and signed authorization.

Your Privacy Rights

Privacy rules and regulations provide you with the following rights:

Revoke Authorizations or Consents. You can revoke any "Authorization" or "Consent" you have given to this office at any time. To revoke an authorization or consent you must put your request in writing. Give it to either the Privacy Officer or the Office Manager.

To Request Restrictions on Use and Disclosure of PHI. You may request restrictions to be placed on the use and/or the disclosure of your PHI. The request may be for special limits for disclosures to your family and other individuals. We are not obligated to agree with your requested restrictions, except in certain instances. To request a restriction, you must put it in writing. Give it to either the Privacy Officer or the Office Manager. If we agree with your request, we will be bound by the request. There is an exception so that emergency treatment can be provided. (45 CFR §164.522(a); (45 CFR §164.510(b)

Receipt of Confidential Communications. You may request to have your PHI sent to another location. You may request the communication be by a different method. You must tell us the different address and different method of communication. There is a charge for this service. 45 CFR §164.522(b).

To See and Copy Your PHI. You may arrange to see your PHI. All requests to see or copy PHI must be in writing. Give the request to the Privacy Officer or Office Manager. If you would like a copy of your PHI, there is a charge for copying and mailing. We may deny your request. In most instances, you have the right to have our denial reviewed. This is outlined in our denial notice. 45 CFR §164.524.

Amend PHI. You may request an amendment to your PHI. All such requests must be in writing. Give it to the Privacy Officer or the Office Manager. The request must include the amendment and reason you are requesting the amendment. We may deny your request. One reason we may deny your request is the medical record you want to amend is not ours. Another reason maybe we believe your medical record is accurate and complete. If you disagree with our refusal, you have the right to submit a written statement of disagreement. It will be attached to your medical record. We have the right to include a rebuttal statement. 45 CFR §164.526.

Use and/or Disclosure Log. You have the right to an accounting of disclosures of your PHI. All such requests must be in writing and submitted to the Privacy Officer or Office Manager. Your request must state the time period, which cannot include a period of time prior to April 14, 2003 or be for more than six (6) years. The first list you request during any twelve (12) month period will be free, however we will charge for all additional lists. We will notify you of all costs associated with providing additional lists so that you can decide if you want to cancel or modify your request before any costs are incurred. 45 CFR §164.528

Copy of Privacy Notice. If you ask for a paper copy of our Privacy Notice, we must give you a copy. 45 CFR § 164.520(b)(1)(iv)(F)

Complaints. You have the right to complain to this office if you believe your privacy rights have been violated. You may also complain to the Secretary of Health of Human Services. To file a complaint, it must be in writing and be submitted to the Privacy Officer or the Office Manager. 45 CFR § 164.520(b)(1)(vi)

The Privacy Officer or Office Manager named below may give you more information. 45 CFR §164.520(b)(2)(vii).

Privacy Officer: Jacque Harper
Address: 2850 Artesia Blvd. Suite 207, Redondo Bch, CA 90278
Telephone No.: (310) 371-4774

Our Privacy Requirements

We are required by federal law to maintain the following:

To keep the privacy of your PHI. To give you this "Privacy Notice" outlining our legal responsibilities and our privacy practices regarding your PHI.

State Privacy Regulations may require us to grant greater access or maintain greater restriction on the use and/or release of your PHI than federal laws and regulations.

We are required to abide by the terms of this "Privacy Notice."

We reserve the right to amend or change the terms of this our "Privacy Notice" and to make the new "Privacy Notice" provisions effective for all your PHI that this office maintains.

This office will distribute any revised "Privacy Notice" before implementation.

This office will not retaliate against you or anyone because they filed a complaint.

Privacy Notice Effective Date

The effective date of this "Privacy Notice" is April 15 2003.

Patient Acknowledgement

I acknowledge that this "Privacy Notice" was made available to me for my review and that I have signed the acknowledgment of receipt to that effect on the consent form filed in may chart. I also understand that I can obtain a copy of the "Privacy Notice" free of charge upon demand.

Please inform your Doctor or Therapist if you have any privacy concerns with sharing *PHI* with other healthcare professionals for the purpose of treatment payment, healthcare operations and coordination of your care or if you have privacy concerns with open treatment rooms.

Copia en Espaňol disponible.