PATIENT INFORMATION

Today's Date _____ Welcome! We appreciate your help in providing this information to complete your medical record
Account Type _____
Patient Acct. # _____
Therapist _____

Have you ever seen one of our therapists before? Yes No

1.Your Name _____

_____
Home Street Address Apt#

_____
City State Zip

Phone _____ _____
Home Work

_____ _____
E-mail Address Cell Phone

Female Male Single Married

Date you return to your Dr. _____

Birth date _____ Age _____

Driver's License# _____

Social Security# _____

Other I.D.# _____

In case of emergency, please notify: Relationship: _____

Name _____

Phone _____ Cell Phone _____

2. Spouse/Parent Info (circle one) _____

_____
Address Apt#

_____
City State Zip

SS# _____ Driver's License# _____

3. Person responsible for payment (check one): Self Spouse

Father Mother Other _____

Payor Name _____
First Middle Last

_____
Address Apt#

_____
City State Zip

Phone _____ _____
Home Work

4. Employer's Name _____

_____
Street Address

_____
City State Zip

5. Identity Theft Security Question (used to help identify you on phone):

_____ ?

Answer: _____

6. Date Injured or Symptoms Started _____

Your Occupation _____

Is your injury or illness: Employment related? Yes No

Accident related? Yes No

7. Do you have another physician following your care that you would like us to send reports to? Yes No

Name _____

How were you referred to us? Doctor Friend Phonebook SignInsurance Internet

Other _____

How did you find our phone number/address? Doctor Friend PhonebookInternetCar's GPSSign Called Map on referral form Other _____

8. Insurance Information: Who may assist you with payment of fees?

Worker's CompensationPrivate insurance Automobile insurance Medicare No insurance

Other _____ Does your insurance require prior authorization?Yes No

9. Primary Insurance _____

Adjuster name _____

Group # _____

Insured ID# _____

Medicare ID# _____

Insured name _____

Address _____
APT#

_____
CITY STATE ZIP

Relationship to insured _____

10. Worker's Compensation Additional Information:

Does your employer consider this a work injury?YesNo

Doctor's name who first examined you _____

Name of employer at time of injury _____

Employer address _____

_____
CITY STATE ZIP

Phone _____

11. I attest that the above stated is correct and true.

Date _____ Patient/Guardian Signature _____

Progressive Physical Therapy - Medical History Form

Name: _____ **DOB:**_____ **Date:**_____

Occupation:_____**Are you on a work restriction from your doctor? Yes No**

Do you have a pacemaker? Yes No Are you latex sensitive? Yes No

FOR WOMEN: Are you currently pregnant or possibly pregnant? Yes No Menopause Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ dizziness/lightheadedness
- ❑ fainting
- ❑ falls
- ❑ trauma
- ❑ deep, throbbing or boring pain in abdomen
- ❑ pain not relieved with rest
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ shortness of breath
- ❑ cough
- ❑ bloody sputum
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ constipation/diarrhea
- ❑ black, tarry stools
- ❑ recent infection
- ❑ headaches
- ❑ cloudy urine
- ❑ blood in urine
- ❑ brown or tea colored urine
- ❑ difficulty with urination
- ❑ any other bladder changes
- ❑ any other bowel changes
- ❑ change in appetite, diet
- ❑ sexual impotence
- ❑ pain with intercourse
- ❑ unusual discharge
- ❑ change in menstrual pattern

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ fibromyalgia
- ❑ hepatitis
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease
- ❑ pelvic inflammatory disease
- ❑ chemical dependency (i.e., alcoholism)
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ HIV or AIDS
- ❑ pneumonia
- ❑ other _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ rheumatalogic disorders
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ endocrine disorders
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications (prescribed or over-the-counter) you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
Do you have a history of smoking? YES NO If yes, how many packs per day? _____
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

Progressive Physical Therapy - Medical History Form

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

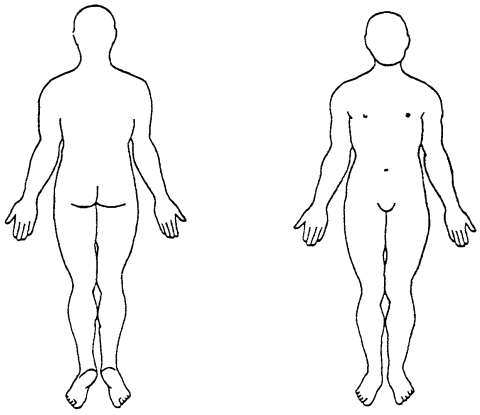
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark all the areas where you feel any symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Reviewed by PT/OT/SLP:

_____
Signature of therapist

This medical information is correct to the best of my knowledge. _____
Signature of Patient ***Date***

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please indicate the ways in which we may contact you.

( ) Home Telephone _____

( ) O.K. to leave message with detailed information on voice mail or with person answering phone

( ) Leave message with call-back number only

( ) Cell Phone _____

( ) O.K. to receive messages via "text" or "sms" messaging

( ) E-mail Address _____

( ) O.K. to fax to this number _____

( ) Work Telephone _____

( ) O.K. to leave message with detailed information on voice mail or with person answering phone

( ) Leave message with call-back number only

( ) Written Communication

( ) O.K. to mail to my home address

( ) O.K. to mail to my work/office address

( ) Other _____

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Note: Uses and disclosures for treatment, payment and/or for our healthcare operations may be permitted without your specific prior authorization.

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records P = Payment Information O = Healthcare Operations A = Authorization on File D = Discretionary
(3) Enter how disclosure was made: F = Fax P = Phone E = Email M = Mail O = Other

Office Policies

We are dedicated to providing highly individualized care for patients with orthopedic injuries. Insurance companies will not dictate the care you receive at Progressive Physical Therapy, Inc. (PPT). Your plan of care is achieved through the professional assessment of your therapist and physician and based on your specific functional goals. Please read the following policies and sign below.

1. Insurance: In order to maintain our high standard of care, PPT is contracted with many insurance companies. As a courtesy to you, the insured, PPT verifies insurance benefits and coverage at the time you begin our professional services. ***This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for and services rendered.*** It is your responsibility to make sure we have the most current information on your insurance, so we may bill it on your behalf. You as the patient, or legal guardian, are responsible for all charges that the carrier does not pay on the claim including any denials, deductibles, co-payments and co-insurance due. You are also responsible for knowing the benefits provided by your insurance coverage including coverage, exclusions and limitations. In the event your insurance company forwards payment directly to you, instead of to Progressive Physical Therapy, Inc., you are required to immediately deliver such payment to Progressive Physical Therapy, Inc. You also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for any costs and court costs, in addition to the outstanding balance.

As verified on _____, you have met _____ of your _____ deductible. We expect your insurance company, to cover _____% of the amount they consider reasonable and customary charges. Your portion should be the remaining _____% plus any additional amount not paid by your insurance company. Additionally, there is a co-payment of $_____ due at each visit. ***Please also note that deductibles must be met prior to insurance payments made on your behalf.*** *Progressive Physical Therapy, Inc. is not responsible for verifying deductible or co-payment amounts. Your insurance allows _____ visits per _____. Please notify us immediately if you have a change in insurance.*

2. Authorization to furnish information: I hereby authorize Progressive Physical Therapy, Inc. to release all medical records concerning my health care to my physician(s), insurance representative(s), insurance carrier(s) and/or legal representative(s). Medical information and records may be released by facsimile, telephone, email and mail.

3. Automobile Accidents: You are responsible for your bill at the time of service. If we can verify that liability has been accepted by the insurance company, that "medical payments" are available under the insurance coverage, and that bills are paid upon receipt (not at time of settlement), we will, as a courtesy to you, bill your insurance company if your credit card is on file with us. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. If payment for services rendered is not received within 30 days of billing, full payment will be due immediately and charged to your credit card.

4. Workers' Compensation: Authorization for treatment from your employer's insurance carrier or employer if self-insured, must be received by Progressive Physical Therapy, Inc. prior to onset of therapy.When the patient's initial authorization has expired or when the authorized physical therapy visits are used, Progressive Physical Therapy, Inc. must have re-authorization from the insurance carrier or employer (if self-insured) for physical therapy to continue.

5. Medicare: Our office accepts Medicare assignment. Medicare payments will come directly to us. The patient will be responsible for charges not paid or covered by Medicare which include, but is not necessarily limited to, the annual deductable, 20% of Medicare approved charges, which is the patient's co-insurance, and costs past the annual $2,010.00 CAP for physical and speech therapy that are not covered by Medicare. We will do our best to inform you prior to reaching your CAP or any uncovered service that we are aware of. If you have received any home health care this year, please let us know.

6. Durable Medical Equipment (DME) and Supplies: DME and supplies are not reimbursable by insurance companies and must be paid for at the time of your therapy session.

7. Payment: Co-Payments are expected when services are rendered (each visit). For your convenience, we can accept payment on a weekly basis. If alternative arrangements are necessary, please contact us directly. We accept VISA, Mastercard, American Express, Discover, debit cards, checks and cash. We expect co-insurance accounts to be paid in full within 30 days from the last day of treatment.

8. Late Charges/Returned Checks: Any account that remains open beyond 30 days from last day of treatment will be subject to a $10.00 fee for each month that the amount is not paid in full. There will be a $35.00 fee for each returned check.

9. Canceled/Missed Appointments: If a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for the session. We require 24 hour notice for cancellations. Appointments that are canceled with less than 24 hours notice or no show appointments are subject to an $85 charge, which is not reimbursable by insurance companies. Also, if a patient late cancels or no-shows more than two times, the patient is responsible for the full charge of the visit and will be taken off of the schedule for any future appointments. _____
Initial

10. Right to Triage: PPT will make every endeavor to see you at your convenience. However, PPT reserves the right to triage clients on emergency cases. You may have to be treated by another therapist. This is our team approach to treatment.

11. Fees: Our fees are subject to change without notice. Please see our fee schedule for all charges. After the initial evaluation, subsequent physical therapy sessions are billed in 15 minute increments and typically range from 30 to 60 minutes in length. As the law requires, each visit will be documented by the therapist during that visit and is part of that visit's time.

12. Consent for Treatment: The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures/modalities as requested by the physician prescribing care. During the evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to you by your therapist. Even though your doctor has referred you to therapy for a certain number of visits or length of time, the therapist will monitor your progress and adjust your treatment accordingly. Should you become ill while undergoing treatment, you give permission to the staff to administer treatments which they consider necessary to your well-being. _____
Initial

13. Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and the services you receive at PPT. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by PPT. We are required by law to make sure that medical information that identifies you is kept private and give you notice of our legal duties and privacy practices with respect to medical information about you.

I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at PPT. In addition, my signature below indicates that I understand and give consent to be treated as explain above.

If a patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent or guardian(s) signature for authorization allows PPT to commence physical therapy, occupational therapy and/or speech therapy treatments with the patient who is a minor. The parent or guardian is also accepting full financial responsibility for the treatment.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's or Guardian's Signature: _____
(If patient is under 18 years)

****

Per the policies described herein, we ask that you authorize us to automatically charge your portion of the bill to your Visa, MasterCard, Discover or American Express.

I hereby authorize**:** **Progressive Physical Therapy, Inc.**, 19510 Ventura Boulevard, Suite 106, Tarzana, California 91356 to apply my balance to my charge card account.

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Account Number: _____ Expiration _____Security Code_____

_____ _____
Cardholder's Signature Date

ASSIGNMENTS OF BENEFITS

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Progressive Physical Therapy, Inc. I authorize Progressive Physical Therapy, Inc. to provide my insurance company any information necessary to process claims for services rendered to me.

_____
Patient Name

_____ _____
Patient Signature (as it appears on your insurance card) Date

MEDICARE

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and I request that payment of medical insurance benefits be made on my behalf to Progressive Physical Therapy, Inc. This authorization shall apply to the period: _____ to _____.

_____
Patient Name

_____ _____
Patient Signature (as it appears on Medicare Card) Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____
Patient Name

_____ _____
Patient Signature (as it appears on MEDIGAP Card) Date

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

As part of my health care, **Progressive Physical Therapy, Inc.** (**Progressive Physical Therapy, Inc.**) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Progressive Physical Therapy, Inc.**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Progressive Physical Therapy, Inc.** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Progressive Physical Therapy, Inc.** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **Progressive Physical Therapy, Inc.**, for **Workers' Compensation Cases**, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Progressive Physical Therapy, Inc.** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

☐ I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

☐ I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Progressive Physical Therapy, Inc. and agree to the liability limitations explained therein.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship to Patient

EMAIL CONFIDENTIALITY NOTICE

Thank you for choosing Progressive Physical Therapy, Inc. for your rehabilitative care. We will do everything possible to exceed your expectations. We'd like to relay some information to you regarding our web-site and email policies:

When you give Progressive Physical Therapy, Inc. authorization to communicate with you via e-mail, your contact information (including your name, address and e-mail address as requested) is added to our secure database located in the United States, and access is limited to authorized persons.

The purpose for our getting your email address is that from time to time, we will send you information about our new programs and equipment, additions to staff, information and updates relating to physical therapy and health care. We want to keep in touch with you and let you know what's happening!

Progressive Physical Therapy, Inc. may share your information with outside "3rd Party" vendors who will be authorized to only use this information solely to perform services (such as a "mailing" house) on our behalf. We will not sell any information given to us, nor allow any party to use your information for other than us communicating with you.

If you choose to give your email address to us via the internet, we will assume that you would like to be included in our database.

If you have questions about our privacy practices, or if you would like your name removed from lists that are used for any of these purposes, simply send your request in writing to:

Stevyn Voyles, Vice President
Progressive Physical Therapy, Inc.
19510 Ventura Boulevard, Suite 106
Tarzana, California 91356

Or email: svoyles@progressivept.net

Please be aware that electronic mail is not a secure means of transmitting information. Progressive Physical Therapy, Inc. cannot guarantee the privacy of information contained in electronic communications. You are not required to communicate with us electronically.

Any electronic communication between you and Progressive Physical Therapy, Inc. may become part of your medical record.

The information contained in electronic transmissions is confidential and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). An electronic transmission is intended for the sole use of the individual or entity to which it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of this message is strictly prohibited. If you received a message in error, please contact the sender immediately by replying to the email and delete the material from any computer.

Electronic communications should not be used for emergency situations. If you have an emergency, dial 911.