PATIENT INFORMATION PLEASE PRINT CLEARLY

Patient Name: _____ Home Phone: _____

Gender:___ Birth Date: _____ Age: _____ Cell Phone: _____

Address: _____ City: _____ State: ___ Zip: _____

Email Address: _____

Occupation/School: _____ Work Phone: _____

Employer: _____ Address: _____

Driver's License #: _____ City: _____ State: ___ Zip: _____

__ Single __ Married __ Divorced __ Separated __ Widowed

Name of spouse or legal guardian: _____

Please provide information regarding the insured or financially responsible individual if other than the patient. Name: _____ Birth Date : _____

Relationship to patient: _____ Home Phone: _____

Employer: _____ Address: _____

Work Phone: _____ City: _____ State: _____ Zip: _____

Type of payment: __ Medical Insurance __ Cash __ Workers Comp __ Auto Insurance __Other

If insurance, please provide carrier name and ID # _____

Secondary insurance carrier name and ID# (if applicable) _____

Is condition due to: Accident? __ Yes __ No Injury? __ Yes __ No Surgery? __ Yes __ No

If yes: __ Auto Accident __ Work Related __ Other, describe _____

Date of accident / injury / surgery: _____

(For workers compensation or auto insurance only):

Adjuster Name: _____ Adjuster Phone: _____

Insurance Carrier: _____ Name of Insured: _____

Who referred you to our services? _____

If referred by a physician, please provide his/her office phone number: _____

PHYSIOWORKS
2621 Manhattan Beach Blvd., Redondo Beach, CA 90278
Tele: (310) 374-0477 FAX: (310) 374-1605

DEAR PATIENT,
There a few policies and procedures that you should be acquainted with before you begin your course of treatment:

1. It is customary for medical facilities to establish a charge for "NO SHOW/LATE CANCEL" APPOINTMENTS. Our charge for such an instance is $40. All patients are expected to be timely with their appointments and to provide a minimum of a 24 hour notice for cancellations. Please be considerate of other patients, as a missed appointment prevents another patient from receiving services. _____(initial)

2. All Payments/Co-payments are due at the time services are rendered unless an agreement has been prearranged. As a courtesy to you, we will bill your insurance carrier and make every reasonable effort to assist in expediting insurance payment. Some insurance companies pay quickly and completely, some pay slowly and only in part or not at all. You are solely responsible for payment of services rendered to you within 90 days of the billing, regardless of the performance of your insurance company. If you have any questions about your eligibility or benefits, please contact your insurance company directly. _____(initial)

3. The patient portion for an initial evaluation visit usually ranges from $100 to $180. _____(initial)

4. As stated by your medical insurance, benefits are only an estimate and NOT a guarantee of payment. Once treatment has been completed, all claims will be reviewed by your medical insurance and then processed accordingly.

ACKNOWLEDGEMENT OF RESPONSIBILITY BY PATIENT

The undersigned accepts financial responsibility to Physioworks for physical therapy services rendered under the terms listed above. Should the account be referred for collection or legal matters, the undersigned will be responsible for the collection, legal, and/or attorney fees/expenses.

I have read the information above and understand that I am solely responsible for payment on my account.

SIGNATURE _____ Date _____
(Patient or Legal Guardian, if minor)

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PLEASE READ AND SIGN:

CONSENT FOR CARE AND TREATMENT:

I give my consent for Robert Maffucci, P.T., Timothy Sullivan, P.T., David Fadale, P.T., Lisa Hardimon, P.T., Emily Varee, P.T. and Colleen Keenan to furnish the medical care deemed necessary and proper in treating the physical condition of myself or the minor under my guardianship (minor's name _____).

_____
Signed by patient or parent/guardian (if patient is a minor)

AUTHORIZATION TO PAY BENEFITS TO PHYSIOWORKS FOR PHYSICAL THERAPY SERVICES:

I hereby assign all medical benefits to which I am entitled, (including Medicare, private insurance and third party payors), to Physioworks. A photocopy of this assignment is to be considered as valid as the original document.

_____
Signed by patient or parent/guardian (if patient is a minor)

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Physioworks to release any information acquired in the course of my examination or treatment to my insurance carrier, insurance agent and or physician.

_____
Signed by patient or parent/guardian (if patient is a minor)

Patient History

Please print the answers for the following questions to the best of your ability. This information will provide for a more efficient and effective evaluation process. All information provided is held in strict confidence.

1. Estimate the number of colds you have experienced in the past year. _____
2. Do you smoke? Y / N If yes, how much? _____
3. What is your alcohol consumption? Daily / Weekly / Monthly / Yearly
4. List all prescription medications you are presently taking.
   Name of medication _____ Date started _____
   Name of medication _____ Date started _____
   Name of medication _____ Date started _____
   Name of medication _____ Date started _____
   Name of medication _____ Date started _____

5. Have you had any of the following diagnostic studies performed for this condition?
   _____ X-Ray
   _____ MRI
   _____ C. T. Scan
   _____ Other (describe) _____

6. Are you presently, or within the past 12 months, under the care of a physician for any of the following?
   _____ Heart disorders
   _____ Kidney disorders
   _____ Respiratory disorders
   _____ Emotional/Psychological
   _____ Sleep disturbances
   _____ Pregnancy
   _____ High blood pressure
   _____ Diabetes
   _____ Arthritis
   _____ Headaches
   _____ Other
   _____
   _____

7. Date of injury or onset of symptoms? _____
8. Please describe your symptoms and where on your body they exist.
   _____
   _____
   _____

9. Are you aware of any movements, positions or activities that make your symptoms better?
   _____
   _____
   _____

10. Are you aware of any movements, positions or activities that make your symptoms worse?
    _____
    _____
    _____

11. What physical activities do you participate in? (i.e. sports, exercise, stretching, housework) And what is the frequency and duration of these activities?

(EXAMPLES)

ACTIVITY	DURATION	FREQUENCY/ PER WEEK
Volleyball	1 – 2 hrs	5 x week
Gardening	1 hr	2 x week

_____
_____
_____
_____

12. Please circle any of these activities of daily living which are inhibited /difficult to perform relating to your symptoms.

Sitting / Standing / Walking / Sleeping / Driving / Dressing / Grooming

Any others? _____

Signature: _____ Date: _____

PHYSIOWORKS

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY

PHYSIOWORKS LEGAL DUTY

Physioworks uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, Physioworks may use your personal health information to contact you to provide appointment reminders, information about your treatment alternatives or other health related benefits that could be of interest to you.
Physioworks may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physioworks policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Physioworks may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENTS INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purpose.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physioworks will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Physioworks may have violated your privacy rights or if you disagree with any decisions we have made regarding the access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Physioworks health information practices, or if you have a complaint, please contact the following person:

Robert Maffucci
2621 Manhattan Beach Blvd.
Redondo Beach, CA 90278

PHYSIOWORKS

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Physioworks Notice of Information Practices. I understand that Physioworks may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Physioworks will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Physioworks Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Signature Signature of Parent/Guardian
(If patient is a minor)

_____
Date