FUNCTION PHYSICAL THERAPY

PATIENT PROFILE

Patient Name (Last, First, Middle Initial): Ms. /Mrs./Mr. _____

Patient Address: _____ City/State/Zip: _____

DOB: _____ Social Security #: _____ Driver's License #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Personal Email: _____

Assistant's Name _____ Assistant's Phone: _____

Please Circle: Single / Married/ Divorced / Widowed Sex: Male/Female

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

Address: _____ (City/State/Zip) _____

Referring Physician: _____

Who can we thank for referring you to Function PT: _____

Occupation: _____ Employer: _____

Employer's Address: _____ (City/State/Zip) _____

Financially Responsible Party if Not Patient

Name: _____ Relation to Patient: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Alt. Phone: _____ Email: _____

Sex: Male/Female Social Security #: _____ Driver's License #: _____

Assignment of Benefits and Authorization to Release Information

NAME OF CLIENT: _____

NAME OF INSURED: _____ INS. DOB: _____

- I hereby instruct and direct my Insurance Company to issue check(s) made out and mailed directly to: Function Physical Therapy for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**
- I further authorize the release of any pertinent information to my Insurance Company, Adjuster or Attorney involved with my case.
- MY CONDITION IS NOT A WORKERS' COMPENSATION CASE OR PART OF A LIEN. (Unless otherwise noted)

Initials _____

I authorize Function Physical Therapy to furnish information to my insurance carriers concerning my treatment, and I hereby assign all payment for services rendered. I agree to pay any outstanding balances after my insurance carrier has paid its portion of the bill.

Patient Signature: _____ **Date:** _____

Office Use Only:
ICD-9 Codes: _____

FUNCTION PHYSICAL THERAPY
PRESENT CONDIITON/MEDICAL HISTORY

Please indicate (x) whether you have or had any of the following conditions:

__ Heart Disease or Heart Attack
__ High Blood Pressure
__ Stroke
__ Hernia
__ Tumor or Cancer
__ Kidney or Bladder Problems
__ Anemia or Other Blood Disorders
__ Bleeding Disorders
__ Respiratory Disease
__ Asthma
__ Epilepsy
__ Diabetes

If you checked any of the above conditions, please explain:_____

_____

Are you pregnant now? Yes No

Do you have any surgical implants (plastic, metal....)? Yes No Explain:_____

_____

Please list all previous surgical procedures with approximate dates:_____

_____

Please list all medications you are currently taking:_____

_____

Please list all allergies:_____

_____

Describe your current condition and areas involved:_____

_____

What is the date of injury/symptoms/surgery:_____

Describe the pain associated with your condition:_____

_____

Rate your pain over the past 48 hours: 0 = No Pain, 10 = severe pain:_____

What activities make your pain worse?_____

What activities alleviate your pain?_____

Pain level at onset:_____

Have you experienced this condition before? If yes, when?_____

_____

Are you currently working?_____

What daily activities are affected by your condition?_____

_____

Have you received previous treatment? If yes, when and where?_____

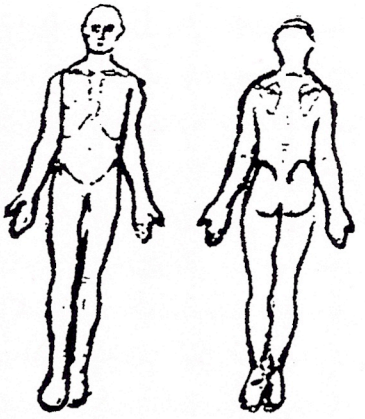
_____

Have you received diagnostic testing(x-rays, MRI..)? _____

Description of symptoms

Mark the areas on the diagram below where you feel the described sensations. Include all affected areas. Please use the symbols below as your indicator.

° = Burning //= Stabbing I. = Numbness √ = Pins/needles Δ = dull ache



Patient Signature: _____

Date:_____

FUNCTION PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

Effective: July 1, 2008

This notice describes how medical information about you may be used or disclosed and how you can obtain access to information. **Please review it carefully.**

Function Physical Therapy's legal duty is to protect the privacy of your personal information, provide this notice about our information practices, and follow practices that are described herein.

USE AND DISCLOSURES OF HEALTH INFORMATION

Function Physical Therapy uses your personal information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, Function Physical Therapy may use your personal health information to contact you to provide appointment reminders, obtain insurance authorization or verify benefits, and informing your physician of your progress of treatment.

In the case of public health purposes, auditing purposes, or for emergencies, Function Physical Therapy may also use or disclose your personal health information without prior authorization. For example, Function Physical Therapy may be required to disclose your personal health information without authorization when requested by judicial administrative release, health oversight release, law enforcement, public health activities, coroners or medical examiners for identification of deceased, and/or specialized government functions.

Function Physical Therapy may change its policy at any time. When changes are made, a new NOTICE OF INFORMATION PRACTICES will be provided to you at your next visit, and will also be posted in the waiting and exam rooms. You may request an updated copy of the NOTICE OF PATIENT INFORMATION at any time.

CLIENT 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 the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ 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
- ☐ O.K. to fax to this number

☐ Other_____

_____

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birth Date

FUNCTION PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

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PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time, the right to request that we correct any inaccurate or incomplete information in your records, and the right to request a list of instances when we have disclosed your personal health information for purposes other than treatment, payment or other related administrative purposes. You may also request in writing that we do not use or disclose your personal health information for treatment, payment and administrative purpose except when specifically authorized by you, when required by law or in emergency circumstances. Function Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

If you are concerned that Function Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the following address below. You may also send a written complaint to the US Department of Health and Human Services.

Function Physical Therapy
Attention: Jonathan Casler
12011 San Vicente Blvd., Suite B-5
Los Angeles, CA 90049

PATIENT INFORMATION CONSENT

I have read and fully understand Function Physical Therapy's NOTICE OF INFORMATION PRACTICES. I understand that Function Physical Therapy may use or disclose my personal health information for the purposes of carrying our treatment, obtaining payment, evaluating the quality of services provided and restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Function Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to such requests, specifically if obligated by law to disclose information.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Function Physical Therapy's 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:_____ Date:_____

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

FUNCTION PHYSICAL THERAPY

FINANCIAL AGREEMENT

- **I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.**

- **It is understood that payment from any third party carrier will not exceed my financial obligation to Function Physical Therapy, and I agree to pay in a current manner, and in accordance with the terms and conditions of Function Physical Therapy, and any balance of said professional fees over and above third party reimbursement, including deductibles, co-payments, exclusions or denials.**

- **I understand that if treatment is suspended or terminated, any fees for professional services rendered will be due and payable upon request.**

- **I understand that any balance remaining over 30 days, following a request/invoice, will result in a 1.5% monthly assessment on the remaining balance.**

- **I will be fully responsible for any legal, collection, or attorney fees if it becomes necessary to resolve the outstanding balance.**

- **Function Physical Therapy will verify your insurance as a courtesy. Verification of coverage is not a guarantee that the insurance company will make payment.**

- **All visits that go beyond the allowed amount by your insurance carrier, or enter into medical review, will be the patient's responsible to pay after each visit. Rates per visit are available at the front office.**

- **Function Physical Therapy encourages you to contact your Insurance carrier for Physical Therapy benefits under the provisions of your plan.**

- **A SERVICE CHARGE OF $100 WILL BE ASSESSED FOR ALL NO SHOWS AND CANCELLATIONS WITHOUT AT LEAST 24 HOURS NOTICE. Cancellations made within 24-hours of the scheduled appointment time are considered a "late cancellation". Leaving a voicemail during closed hours, as long as at least 24 hours giving, is an acceptable means of cancellation. Emails, text messages, or faxes are not acceptable means of cancellation.**

_____
Initials

_____ ____/____/____
Signature of Policy holder/Responsible Party Date

_____ ____/____/____
Signature of claimant/Responsible Party Date

_____ ____/____/____
Witness Date