PLAYA PHYSICAL THERAPY

Date: _____

Referring Doctor: _____

## PATIENT INFORMATION

Last Name: _____First: _____M.I.: ____

Address: _____Apt: _____

City: _____State: _____Zip: _____

Phone Numbers: Home: _____Cell: _____

Email address:_____
Would you like to receive our free monthly e-mail newsletter? Yes _____ No _____

**Date of Birth**: _____SS#: _____Sex: ____M____F

Marital Status: M ____S _____D _____W ____Spouse's Name: _____
Emergency Contact Name/Phone: _____

Is this injury related to:

Work? Yes ____No ____ Auto Accident? Yes ____No ____ Other? Yes ____No ___

Date of Injury: _____Is there an attorney involved? Yes____ No____

## PATIENT WORK INFORMATION

Employer's Name: _____

Employer's Address: _____

City: _____State: _____Zip: _____

Work Phone Number: _____Ext: _____

### WORKERS COMP INSURANCE

Workers Comp Carrier: _____

Address: _____State: _____Zip: _____

Insurance Adjustor: _____Claim #: _____

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Ph: 310-823-2220 Fax: 310-823-2636 Website: www.PlayaPT.com

PLAYA PHYSICAL THERAPY

## PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Height_____ Weight_____

Referring Physician: _____

Family Physician: _____
Date of First Doctor Visit for This Injury/Condition: _____

Date of onset of Symptoms/Injury: _____ Injury Type: Auto ___ Work Related ___
Other: _____

Have you had surgery for this Injury/Condition: YES NO
Type of Surgery: _____
Date(s) of Surgery: _____

Are you Allergic to any medications: YES NO

List Medications: _____

Last Date Worked Due to this Injury/Condition: _____

Date Returned to Work after this Injury/Condition: _____

Is an Attorney Involved in this Case: YES NO

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

| | YES | NO | | YES |
|---|---|---|---|---|
| Chiropractor | ____ | ____ | CT Scan | ____ |
| EMG/NCV | ____ | ____ | General Practitioner | ____ |
| Massage Therapy | ____ | ____ | MRI | ____ |
| Myelogram | ____ | ____ | Neurologist | ____ |
| Occupational Therapy | ____ | ____ | Orthopedist | ____ |
| Physical Therapy | ____ | ____ | Podiatrist | ____ |
| Emergency Room Care | ____ | ____ | X-Rays | ____ |
| Other: | ____ | | | |

List any other information that would assist us in your care:
_____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO What are your rehabilitation expectations/goals while in this physical therapy program?
_____

Patient/Responsible Party Signature: _____ Date: _____

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# Medical History

## Existing or Relevant Previous Conditions

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ◯ Yes ◯ No | Dizzy Spells | ◯ Yes ◯ No | MRSA | ◯ Yes ◯ No |
| Anemia | ◯ Yes ◯ No | Emphysema/Bronchitis | ◯ Yes ◯ No | Multiple Sclerosis | ◯ Yes ◯ No |
| Anxiety | ◯ Yes ◯ No | Fibromyalgia | ◯ Yes ◯ No | Muscular Disease | ◯ Yes ◯ No |
| Arthritis | ◯ Yes ◯ No | Fractures | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | Gallbladder Problems | ◯ Yes ◯ No | Parkinsons | ◯ Yes ◯ No |
| Autoimmune Disorder | ◯ Yes ◯ No | Headaches | ◯ Yes ◯ No | Rheumatoid Arthritis | ◯ Yes ◯ No |
| Cancer | ◯ Yes ◯ No | Hearing Impairment | ◯ Yes ◯ No | Seizures | ◯ Yes ◯ No |
| Cardiac Conditions | ◯ Yes ◯ No | Hepatitis | ◯ Yes ◯ No | Smoking | ◯ Yes ◯ No |
| Cardiac Pacemaker | ◯ Yes ◯ No | High Cholesterol | ◯ Yes ◯ No | Speech Problems | ◯ Yes ◯ No |
| Chemical Dependency | ◯ Yes ◯ No | High/Low Blood Pressure | ◯ Yes ◯ No | Strokes | ◯ Yes ◯ No |
| Circulation Problems | ◯ Yes ◯ No | HIV/AIDS | ◯ Yes ◯ No | Thyroid Disease | ◯ Yes ◯ No |
| Currently Pregnant | ◯ Yes ◯ No | Incontinence | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No |
| Depression | ◯ Yes ◯ No | Kidney Problems | ◯ Yes ◯ No | Vision Problems | ◯ Yes ◯ No |
| Diabetes | ◯ Yes ◯ No | Metal Implants | ◯ Yes ◯ No | | |

## Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

## Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

## Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

## Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

PLAYA PHYSICAL THERAPY

# INFORMED CONSENT

**POLICY:**

Before medical care can be rendered or medical procedure is undertaken, consent to such care or treatment must be obtained from the patient, from an adult family member, or an authorized guardian for the patient. Information given to the consenter should include the following: diagnosis of condition, proposed treatment, risk and precautions. Legal consent may be obtained from the following:

- The patient, if at least eighteen (18) years old, or married and if physical and mental condition permits.
- A parent or legal guardian, if a minor is involved, either in person or by phone if witnessed by a licensed staff member.
- Any person or educational institution with written authorization from the person who would otherwise have the power.
- The court having jurisdiction of the patient.
- In some situations a minor may give consent if the minor:
  - Is on active duty with this nation's armed forces
  - Is at least sixteen (16) years old, lives apart from his/her parents and manages his/her own financial affairs.
- Any adult family member (e.g. grandparent, brother, sister, aunt or uncle) in the event that the parent or legal guardian cannot be located.
- The parent having custody of a child of divorced or separated parents, whenever possible.

A consent form must be signed by the patient, legal guardian or authorized person responsible for the patient. The consent form includes permission to treat in accordance with the physician's orders and release of information to third-party payers. The consent form also contains a statement, which indicates that the patient was given a copy of the Patient's Bill of Rights. The Authorization for Treatment will also inform the patient of their right to access protective agencies, right to communication during treatment or restriction thereof, right to complain and right to privacy.

The Authorization for Treatment and Patient's Bill of Rights will be signed and dated by the patient, in duplicate. The original will be added to the patient's chart and the patient will keep a copy.

Patient's Signature_____ Date_____

Witness_____ Date_____

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PLAYA PHYSICAL THERAPY

# Cancellation and "No-show" Policy

It is important for you to attend your scheduled appointments to achieve the goals that you, your physician, and your therapist have established.

If you must cancel a scheduled appointment, please call the office at the number below as soon as possible. For your convenience, our telephones are on an automatic answering machine during off hours.

Playa Physical Therapy

310-823-2220

The following is our policy for cancellations and "no-shows" (missed appointments without calling to cancel).

- If you cancel with notice of less than 24 hours or "no-show" for an appointment, a $35.00 fee will be charged. For consideration of reversal of this charge with a legitimate excuse you must speak to one of the owners of Playa Physical Therapy. The receptionist does not have the authority to make these decisions.

I have read the Cancellation and "No-Show" Policy of Playa Physical Therapy and I understand its contents.

_____
Patient's Signature

_____
Date

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PLAYA PHYSICAL THERAPY

# AUTHORIZATION FOR TREATMENT

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin or disability.

The purpose of physical therapy is to treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, exercises and physical agents including, but not limited to mechanical devices, heat, cold, air, light, water, electricity and sound in the aid of diagnosis or treatment; to obtain for the physician information needed in diagnosing and evaluation of patients; to prevent or minimize residual physical and mental disability; to aid the patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery.

You are expected to cooperate fully with the evaluation and stop any test or treatment before any increase in your current level of pain or discomfort. Because of the nature of services provided, you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

There are certain inherent risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The Physical Therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The clinic reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect and/or exploitation of patients. Should you observe any abuse, neglect or exploitation by an individual in the department you are encouraged to report it immediately. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies and if necessary be given appropriate privacy to complete your communication with those individuals/agencies.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities and authorize release of medical information to appropriate third parties.

**NOTICE TO PATIENTS:**

For your personal safety, do not use any equipment without a staff member present.

Patient's Signature_____ Date_____

Witness_____ Date_____

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PLAYA PHYSICAL THERAPY

# NOTICE OF PRIVACY PRACTICES

We protect the privacy of our patient's health information as required by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

**Your Health Information**
**This notice describes the medical information about you that may be used and disclosed and how you can get access to this information. Please review carefully.**

We collect, use, and disclose information provided by and about you for medically necessary treatment, health care payment and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required by Law: Information provided by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order of subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization at any time in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

PLAYA PHYSICAL THERAPY

**Your Rights**
Under regulations that will be in effect on April 24, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communication to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

**Complaints**
If you believe that your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

**Copies and Changes**
You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

**Contact Information**
If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact our privacy officer, Josiah Anderson, at (310)823-2220.

**Declaration of Privacy of Health Information**
All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services(HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Further, I agree that the results of any assessments or medical records may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports, and medical billing and reimbursement. I understand that such reports will only report aggregated data and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors, and administrators.

Restrictions requested by patient: _____
_____

Patient's Signature_____ Date_____

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# RELEASE AND WAIVER OF LIABILITY

In consideration of being permitted to enter the premises at *13163 "A" Fountain Park Drive in Playa Vista, California* ("Premises") for any purpose whatsoever including, but not limited to the observation, participation or use of any of the facilities or equipment therein, the Undersigned does hereby release, waive, covenant not to sue and forever discharge and hold harmless *Playa Physical Therapy, Inc., VisionFitnessWellness, LLC, Essex Fountain Park Apartments, LP, Natania Goldberg and Aaron Willis individually, and all of their officers, subsidiaries, parent companies, agents, employees, affiliates and assigns* (collectively the "Releasees") from any and all loss or damage, and any claim, demand, right or causes thereof on account of injury to the person or property or resulting in the death of the undersigned, whether caused by the negligence of the releases or otherwise while the undersigned is in, upon, or about the premises or any facilities or equipment therein.

The Undersigned does hereby assume full responsibility for and risk of bodily injury, death or property damage due to the negligence of Releasees or otherwise while in, about or upon the Premises and/or while using the Premises or any facilities or equipment hereon.

The Undersigned further expressly agrees that the foregoing Release and Waiver of Liability is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY**, and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

_____ _____

**Signature** **Date**

_____

**Print Name**

**IF PARTICIPANT IS UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST ALSO SIGN BELOW:**

_____ _____

**Signature of Parent** **Date**

_____

**Print Name**

PLAYA PHYSICAL THERAPY

## MEDICARE INFORMATION

Medicare Number: _____

## PRIVATE INSURANCE INFORMATION

**Insured Person Name**: _____Is this your coverage? Y N

**Insured Date of Birth:** _____Relationship to Patient: _____

Policy Number: _____Group Number: _____

Insurance Company Name: _____

Address: _____State: _____Zip: _____

Phone Number: _____Contact: _____

## SECONDARY INSURANCE

**Insured Person Name**: _____

**Insured Date of Birth:** _____Relationship to Patient: _____

Policy Number: _____Group Number: _____

Insurance Company Name: _____

Address: _____State: _____Zip: _____

Phone Number: _____Contact: _____

Authorization to Release Information and Assignment of Benefits:

I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plan to Playa Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature: _____ Date: _____

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