Westside
Wellness &
Rehabilitation
Physical Therapy ▪ Sports Medicine ▪ Wellness

Patient Information:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home phone: _____ **Work phone:** _____

DOB: _____ **E-mail:** _____ **Sex:** _____

Employer: _____ **Occupation:** _____

Car

Make: _____ **Model:** _____ **Year:** _____

Spouse or Parent/Guardian:

Name: _____ **Relationship to patient:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Employer: _____ **Work phone:** _____

Emergency Contact:

Name: _____ **Phone:** _____

Injury Information:

Date of injury: _____ **Date of Surgery:** _____

MEDICAL HISTORY FORM

NAME:_____ OCCUPATION:_____ AGE:_____

DATE OF ONSET: Injury/Problem/Surgery: _____

Briefly state previous treatment, if any: _____

_____

Do you have now, or have you ever had, any of the following:

DIABETES	YES___NO___	ALLERGY TO COLD	YES__ NO___
HIGH BLOOD PRESSURE	YES__ NO___	OTHER ALLERGIES	YES__ NO___
PACEMAKER	YES__ NO___	PREVIOUS SURGERY	YES__ NO___
CHRONIC HEADACHES	YES__ NO___	SIEZURES	YES__ NO___
KIDNEY PROBLEMS	YES__ NO___	METAL IMPLANTS	YES__ NO___
NERVOUS DISORDERS	YES__ NO___	DIZZINESS	YES__ NO___
HERNIA	YES__ NO___	CANCER	YES__ NO___
ALLERGY TO HEAT	YES__ NO___	PREGNANT	YES__ NO___
BONE DISEASE	YES__ NO___	OSTEOPOROSIS	YES__ NO___
FRACTURES	YES__ NO___	BOWEL PROBLEMS	YES__ NO___
BLADDER PROBLEMS	YES__ NO___	RECENT WEIGHT LOSS	YES__ NO___
PINS & NEEDLES	YES__ NO___	CIRCULATORY DISEASE	YES__ NO___
PROBLEMS WITH BOTH ARMS OR LEGS AT THE SAME TIME			YES__ NO___

If YES to any of the above, please explain and give appropriate details: _____

_____

_____

Are you presently taking any medications? YES___NO___

If YES, please list your medications and for what condition: _____

_____

_____

Have you had any X-rays, CAT scans, MRI's, or other diagnostic tests for your recent disorder?
YES__ NO___ If YES, please explain the findings as you understand them. _____

_____

_____

Is there anything else you think I should know about your general health, or current condition?
Please explain and, if necessary, we can talk about it: _____

_____

_____

Westside Wellness & Rehabilitation

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Consent to Treat:

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, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, including mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you might be asked to 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, or stop the procedure. Please let us know immediately if you have any problems.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop any treatment or exercise if you feel any undo discomfort or pain. Your 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 that you do not wish to perform.

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 have read and received a copy of the consent form and authorize release of medical information to appropriate third parties.

Signature: _____ **Date:** _____
(Patient or Parent/Legal Guardian)

Credit Card Registration

INSURANCE PATIENTS: I understand that I am financially responsible for all fees incurred for my own/my child's/my legal ward's treatment, even if I have insurance that may cover cost partially or in full. I further agree that Westside Wellness & Rehabilitation may bill my credit card, the number of which is registered below, for my initial visit until insurance verification, as well as for any co-payment/ co-insurance/ visits for which my deductible has not been satisfied, and for any treatments disputed by my insurance company or payments delayed or denied for reasons beyond the control of Westside Wellness & Rehabilitation.

NON INSURANCE CLIENTS: I chose to register my credit card in lieu of cash or check payments at the time of service.

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV/CVC # _____

Please Circle: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Your signature below indicated your agreement to the terms above.

Signed: _____

_____

Today's Date: _____

Cancellation/No-show Policy:

ALL cancellations must be made a **MINIMUM** of 24 hours prior to your scheduled appointment time, or by 4 pm the Friday PRECEDING a Monday's scheduled appointment time. If you fail to cancel 24 hours ahead (or Friday 4 pm for Monday appointments), **$75** will be charged to your credit card on file for the missed appointment. If you No-show for a scheduled appointment, **$100** will be charged to your credit card on file. *YOUR INSURANCE DOES NOT COVER THIS AND MAY NOT BILLED FOR ANY LATE CANCELLATION OR NO-SHOW*

Signature: _____

Today's Date: _____

Westside Wellness & Rehabilitation
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Assignment of Benefits

Patient name: _____DOB:_____

Primary Insurance Company: _____
Patient Identification and/or group number: _____
Billing address: _____
Phone: _____

Secondary Insurance Company: _____
Patient Identification and/or group number: _____
Billing address: _____
Phone: _____

I hereby authorize Westside Wellness and Rehabilitation to provide to my insurance carrier(s) any and all requested information regarding my health care. I also authorize my insurance carrier(s) to direct payment to Westside Wellness and Rehabilitation/Amy Fee Physical Therapy Inc and/or Amy B Fee DPT for services rendered as individual insurance benefits permit.

I understand that I am fully responsible to know my own insurance benefits and limitations and am ultimately responsible for any outstanding balance.

Signature: _____ Date: _____
(Patient and/or Parent/Guardian)

NOTICE OF PRIVACY PRACTICE

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 HOW MEDICAL INFORMATION ABOUT YOU 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 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 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 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 or 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.

Your Rights

Under regulations that are in effect since April 14, 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 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 communications to your home address could endanger you.
- Receive an accounting of your 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 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 or 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 at 310-827-1551.

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 HIPPA (Health Insurance Portability and Accountability Act of 1996).

Further, I authorize that the results of any assessments or records given to me 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 client:

_____

_____

Signature of Client: _____ Date: _____