

Balance Physical Therapy & Human Performance Center, Inc.

143 John Street Salinas, CA 93901 Phone: (831) 422-4782 Fax: (831) 422-4784

PATIENT INFORMATION

*****Please present your insurance card(s) for copying*****

Patient Name:		Date of Birth:		Age:	Sex: M F
Social Security Number:	Employment Status: Emp Unemp Retired Student			Marital Status: Single Married Other	
Address:		City, State, Zip Code		E-Mail Address:	
Home Phone:		Work Phone:		Cell Phone:	
Employer:			Referring MD:		
Emergency Contact:		Relationship:		Home Phone:	
Address:		City, State, Zip		Work Phone:	
Financial Party: (if patient is a minor)		Relationship:	Social Security Number:		Date of Birth:
Home Phone:	Work Phone:	Employer:			

OFFICE PAYMENT POLICY

It is the policy of Balance Physical Therapy & Human Performance Center, Inc that payment is due and to be made at the time service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 60 minutes long, and vary depending upon the type of treatment being performed.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the receptionist and we will verify your coverage as a courtesy. Although we are contracted with some insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manager before starting your treatments.

INFORMED CONSENT POLICY Consent for Physical Therapy Treatment

The above information is correct to the best of my knowledge. In signing below, I agree to be treated by the staff of Balance Physical Therapy & Human Performance Center, Inc as prescribed by my physician and recommended by my physical Therapist. If I would become ill while undergoing treatment at Balance Physical Therapy & Human Performance Center, Inc., I give permission to the staff to administer treatments which they consider necessary to my well-being. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Balance Physical Therapy & Human Performance Center, Inc. I authorize payment of medical benefits directly to Balance Physical Therapy & Human Performance Center, Inc. I understand that I am financially responsible to Balance Physical Therapy & Human Performance Center, Inc. for all unpaid balances.

Patient's Signature: _____ **Date:** _____

(Guardian's Signature if Patient is a minor)

Balance Physical Therapy & Human Performance Center, Inc.

PATIENT MEDICAL HISTORY FORM

Name:	Age:	Current Concern/Problem:	Date of Onset:
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I. HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? (Fill in the appropriate circles)

1. CANCER	YES <input type="radio"/>	NO <input type="radio"/>	Type(s), include date of diagnosis:
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2. INFECTION:	Yes	No	3. CARDIOVASCULAR:	Yes	No
Chronic Urinary Tract/Kidney Infection	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>
Pneumonia	<input type="radio"/>	<input type="radio"/>	Deep Venous Thrombosis (DVT)	<input type="radio"/>	<input type="radio"/>
Bone/Joint Infection	<input type="radio"/>	<input type="radio"/>	Arterial Blockage of the Legs	<input type="radio"/>	<input type="radio"/>
Viral Conditions	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Other Infection: (Please List Below)	<input type="radio"/>	<input type="radio"/>	Stroke / TIA	<input type="radio"/>	<input type="radio"/>
			Other: _____		

4. GENERAL MEDICAL CONDITIONS:	Yes	No	4. GENERAL MEDICAL CONDITIONS:	Yes	No
Rheumatologic Disorders	<input type="radio"/>	<input type="radio"/>	Osteoarthritis: (Wear-and-Tear Arthritis)	<input type="radio"/>	<input type="radio"/>
Lung Disorders	<input type="radio"/>	<input type="radio"/>	Osteoporosis / Osteopenia	<input type="radio"/>	<input type="radio"/>
Liver / Kidney Conditions	<input type="radio"/>	<input type="radio"/>	Dizziness or falls	<input type="radio"/>	<input type="radio"/>
Gastrointestinal Disorders	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>
Neurological Disorders	<input type="radio"/>	<input type="radio"/>	Bowel / Bladder Incontinence	<input type="radio"/>	<input type="radio"/>
Anemia / Blood Disorders	<input type="radio"/>	<input type="radio"/>	Headaches (more than 1 per week)	<input type="radio"/>	<input type="radio"/>
Thyroid Conditions	<input type="radio"/>	<input type="radio"/>	Vision or hearing difficulty	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	Immunologic / Allergy Conditions	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Genitourinary / Gynecologic Conditions	<input type="radio"/>	<input type="radio"/>
Dermatologic Conditions	<input type="radio"/>	<input type="radio"/>	Other conditions: _____		

II. PLEASE LIST ALL MEDICATIONS INCLUDING FREQUENCY AND DOSAGE: (Over-the-Counter and Prescribed)

	Frequency	Dosage		Frequency	Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

III. SURGERIES AND / OR HOSPITALIZATIONS:	Date:	IV. OTHER CURRENT CONDITONS:	Yes	No
1.	Date:	1. Recent, unplanned weight loss?	<input type="radio"/>	<input type="radio"/>
2.	Date:	2. Unexplained night pain?	<input type="radio"/>	<input type="radio"/>
3.	Date:	3. Fevers or night sweats?	<input type="radio"/>	<input type="radio"/>
4.	Date:	4. Nausea / Vomiting?	<input type="radio"/>	<input type="radio"/>
5.	Date:	5. Unexplained weakness or fatigue?	<input type="radio"/>	<input type="radio"/>
6.	Date:	6. Are you currently pregnant? (Women only)	<input type="radio"/>	<input type="radio"/>

V. HEALTH-RELATED HABITS					
Smoking	Yes	No	Caffeine (3 soda Cans = 1 cup)	Yes	No
If yes, < 1 pack/day?	<input type="radio"/>	<input type="radio"/>	0-2 cups?	<input type="radio"/>	<input type="radio"/>
If yes, > 1 pack/day?	<input type="radio"/>	<input type="radio"/>	> 2 cups/day?	<input type="radio"/>	<input type="radio"/>
Ice Sensitive?	<input type="radio"/>	<input type="radio"/>	Heat Sensitive?	<input type="radio"/>	<input type="radio"/>
Previous Experience with physical therapy?	<input type="radio"/>	<input type="radio"/>	Where and Why?		
			Alcohol (Circle 1 each column)		
			0-2 days a week		0-3 drinks/week
			-5 days a week		5-7 drinks/week
			6-7 days a week		7+ drinks/week

***Please use other side of paper if additional space is needed.

I affirm that the above information is accurate and true.

Patient's Signature: _____ Date: _____ Therapist Review: (Initials) _____

(Guardian's Signature if patient is a minor)

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓒ The pain comes and goes and is moderate.
- Ⓜ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓒ Because of pain my normal sleep is reduced by less than 25%.
- Ⓜ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓠ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓒ Pain prevents me from sitting more than 1 hour.
- Ⓜ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓠ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓒ I cannot stand for longer than 1 hour without increasing pain.
- Ⓜ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓠ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓒ I cannot walk more than 1 mile without increasing pain.
- Ⓜ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓠ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓒ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓜ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓠ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓠ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓒ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓜ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓠ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓜ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓠ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓒ My pain seems to be getting better but improvement is slow.
- Ⓜ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓠ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Balance Physical Therapy & Human Performance Center, Inc.

MEDICAL RECORDS RELEASE

Please Print

Patient's First Name:	M.I.:	Last Name:	DOB:
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- No, I do not authorize Balance Physical Therapy to obtain medical records relating to my present condition.
- Yes, I authorize Balance Physical Therapy to obtain the following medical records relating to my present condition.

I, the undersigned, do hereby authorize _____ to release
(Name of Physician or office)
copies of the following records to Balance Physical Therapy & Human Performance Center, Inc.

<input type="checkbox"/> Office Visits	Date: _____
<input type="checkbox"/> Operative Report	Date: _____
<input type="checkbox"/> Radiology Reports	Date: _____
<input type="checkbox"/> X-Ray	Date: _____
<input type="checkbox"/> MRI	Date: _____
<input type="checkbox"/> CT	Date: _____
<input type="checkbox"/> Bone Scan	Date: _____
<input type="checkbox"/> Other	Date: _____

<small>(Please Specify)</small>	

Patient's Signature: _____ Date: _____
(Guardian's Signature if patient is a minor)

Balance Physical Therapy & Human Performance Center, Inc.

NOTICE OF PRIVACY PRACTICES

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

BALANCE PHYSICAL THERAPY'S LEGAL DUTY

Balance Physical Therapy & Human Performance Center, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our privacy practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Balance Physical Therapy & Human Performance Center, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Balance Physical Therapy & Human Performance Center, Inc. may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our 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 future disclosures at any time.

Balance Physical Therapy & Human Performance Center, Inc. may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room and one will be provided to you at your next visit. You may also request an updated copy of our Notice of Privacy Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. If you request copies we may charge you a fee. You may contact us using the information listed at the end of this notice for a full explanation of our fee structure. 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 purposes. You may also request in writing that we do not use or disclose your personal health information for treatment, payment and administrative purposes except when required by law or in emergency circumstances. Balance Physical Therapy & Human Performance Center, Inc. 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 we may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our office manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services at the address listed below.

Balance Physical Therapy & Human Performance Center, Inc.

Attn: Jessica Murillo, Practice Manager

143 John Street

Salinas, CA 93901

www.balancept.com

Phone: (831) 422-4782 Fax: (831) 422-4784

US Department of Health and Human Service

200 Independence Avenue, S.W.

Washington, DC 20201

www.os.dhhs.gov

*****Please retain this copy for your records*****

Balance Physical Therapy & Human Performance Center, Inc.

143 John Street Salinas, CA 93901 Phone: (831) 422-4782 Fax: (831) 422-4784
160 Harden Pkwy, Ste 101 Salinas, CA 93906 Phone: (831) 442-7110 Fax: (831) 442-2358

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read and fully understand Balance Physical Therapy & Human Performance Center, Inc., Notice of Privacy Practices. I understand that Balance Physical Therapy & Human Performance Center, Inc. may use or disclose my personal health information for the purposes 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 Balance Physical Therapy & Human Performance Center, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Balance Physical Therapy & Human Performance Center, Inc. Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient's Name: _____ **Patient's D.O.B:** _____
(Please Print)

Patient's Signature: _____ **Date:** _____

Balance Physical Therapy & Human Performance Center, Inc.

143 John Street Salinas, CA 93901 ♦ Phone: 831-422-4782 Fax: 831-422-4784

CANCELLATION / NO-SHOW POLICY

At Balance Physical Therapy, we pride ourselves on quality patient care while providing a level of service that exceeds your expectations. In order to do so, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment times. All appointments not kept without at least 24 hours notice are subject to a \$25.00 fee. Thank you for your understanding and your commitment to your recovery.

I, the undersigned, accept responsibility for my scheduled appointments, and I understand that I will be charged \$25.00 for appointments that are cancelled or not kept without 24-hour advance notice.

Print Patient Name: _____

Patient Signature: _____

Date: _____