

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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D. 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:	Yes	No
1. _____ Date: _____	<input type="radio"/>	<input type="radio"/>
2. _____ Date: _____	<input type="radio"/>	<input type="radio"/>
3. _____ Date: _____	<input type="radio"/>	<input type="radio"/>
4. _____ Date: _____	<input type="radio"/>	<input type="radio"/>
5. _____ Date: _____	<input type="radio"/>	<input type="radio"/>
6. _____ Date: _____	<input type="radio"/>	<input type="radio"/>

IV. OTHER CURRENT CONDITONS:	Yes	No
1. Recent, unplanned weight loss?	<input type="radio"/>	<input type="radio"/>
2. Unexplained night pain?	<input type="radio"/>	<input type="radio"/>
3. Fevers or night sweats?	<input type="radio"/>	<input type="radio"/>
4. Nausea / Vomiting?	<input type="radio"/>	<input type="radio"/>
5. Unexplained weakness or fatigue?	<input type="radio"/>	<input type="radio"/>
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	Alcohol (Circle 1 each column)	
If yes, < 1 pack/day?	<input type="radio"/>	<input type="radio"/>	0-2 cups?	<input type="radio"/>	<input type="radio"/>	0-2 days a week	0-3 drinks/week
If yes, > 1 pack/day?	<input type="radio"/>	<input type="radio"/>	> 2 cups/day?	<input type="radio"/>	<input type="radio"/>	3-5 days a week	5-7 drinks/week
Ice Sensitive?	<input type="radio"/>	<input type="radio"/>	Heat Sensitive?	<input type="radio"/>	<input type="radio"/>	6-7 days a week	7+ drinks/week
Previous Experience with physical therapy?	<input type="radio"/>	<input type="radio"/>	Where and Why?				

***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)

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
Column Totals:						

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses to AON.
 Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network. *The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application*, *Physical Therapy*, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

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.

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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: _____