

New Life

Physical Therapy, Inc.

GENERAL PATIENT INFORMATION

(THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL)

DATE _____

PATIENTS LAST NAME FIRST NAME MIDDLE HOME PHONE

CURRENT STREET ADDRESS CITY STATE ZIP HOW LONG

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER WORK PHONE EXT. CELL PHONE

EMPLOYED BY EMPLOYER'S ADDRESS

OCCUPATION DATE OF BIRTH AGE SEX: MALE FEMALE

EMAIL ADDRESS: _____ MAY WE USE YOUR EMAIL ADDRESS TO CONTACT YOU REGARDING YOUR APPOINTMENT SCHEDULE? YES ON NOTE: WE DO NOT SHARE ANY PATIENT INFORMATION, ONLY NEW LIFE WILL UTILIZE YOUR EMAIL.

MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY RELATIONSHIP EMERGENCY PHONE

CURRENT STREET ADDRESS CITY STATE ZIP

WHO REFERRED YOU TO THIS OFFICE _____

INSURANCE ASSIGNMENT

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY IRREVOCABLY ASSIGN AND TRANSFER ALL BENEFITS WHETHER CONTRACTUAL, STATUTORY, OR COMMON LAW TO NEW LIFE PHYSICAL THERAPY, INC. FOR ALL AMOUNTS DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AM AWARE OF THE FACT THAT VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT AND THAT I AM FULLY RESPONSIBLE FOR PAYMENT IN FULL IN THE EVENT MY INSURANCE CARRIER(S) DOES NOT COVER ANY OR ALL INCURRED CHARGES AT NEW LIFE PHYSICAL THERAPY, INC.

OUR OFFICE WILL BILL YOUR INSURANCE CARRIER(S) AS A COURTESY TO YOU. IF YOUR INSURANCE CARRIER SENDS PAYMENT DIRECTLY TO YOU, YOU WILL BE RESPONSIBLE TO FORWARD THESE PAYMENTS TO OUR BUSINESS OFFICE IMMEDIATELY UPON RECEIPT. ALL PATIENT BALANCES 60 DAYS PAST DUE WILL BE ASSESSED A FINANCE CHARGE.

RESPONSIBLE PARTY'S SIGNATURE DATE

Rev 04/15/09

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Consent to Treat Authorization

I, _____ do hereby
consent to be treated for physical therapy by New Life Physical Therapy.

Patient Signature: _____ Date: _____

Rev. 05/09

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ADMISSION FORM

History and Physical Condition Information

Answers to the following questions will assist the Therapist in providing a safe and effective program.

NAME: _____ AGE: _____

Referring Physician: _____ Today's Date: _____

Primary Care Physician: _____ Best Contact Phone#: _____

Problems to be treated: _____

Have you had treatment for this problem before? YES NO

If YES, state where: _____ When: _____

Treatment given: _____

Have you had surgery associated with this problem? YES NO

If YES, please list date and type of surgery: _____

List any other major illness or surgery that has occurred in the past year: _____

Are you currently taking any medications? YES NO

If YES, please list all medications: _____

Have you ever had Physical Therapy before? YES NO

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

High Blood Pressure	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Incontinence	YES	NO

If YES on any of the above, please explain and give approximate dates: _____

If Yes to High Blood Pressure, are you taking medication: YES NO.

Has a doctor ever told you that have a medical condition that requires you to restrict your cardiovascular exercise: YES NO.

Answers to the following questions will assist the social worker in providing any necessary referral.

Do you need assistance with any of the following?

Transportation	YES	NO	Meals	YES	NO
Shopping/Errands	YES	NO	Personal Care	YES	NO
Domestic Chores	YES	NO	Other _____		

Has your illness/disability caused any of the following?

Financial Problems	YES	NO	Family Problems	YES	NO
Emotional Problems	YES	NO	Other _____		

Are you currently receiving assistance for any of the above problems? YES NO

The above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Reviewed with patient by: _____ Date: _____

Social service referrals recommended? YES NO

Reviewed by L.C.S.W. _____ Date: _____

Comments: _____

Rev. 10/08

New Life

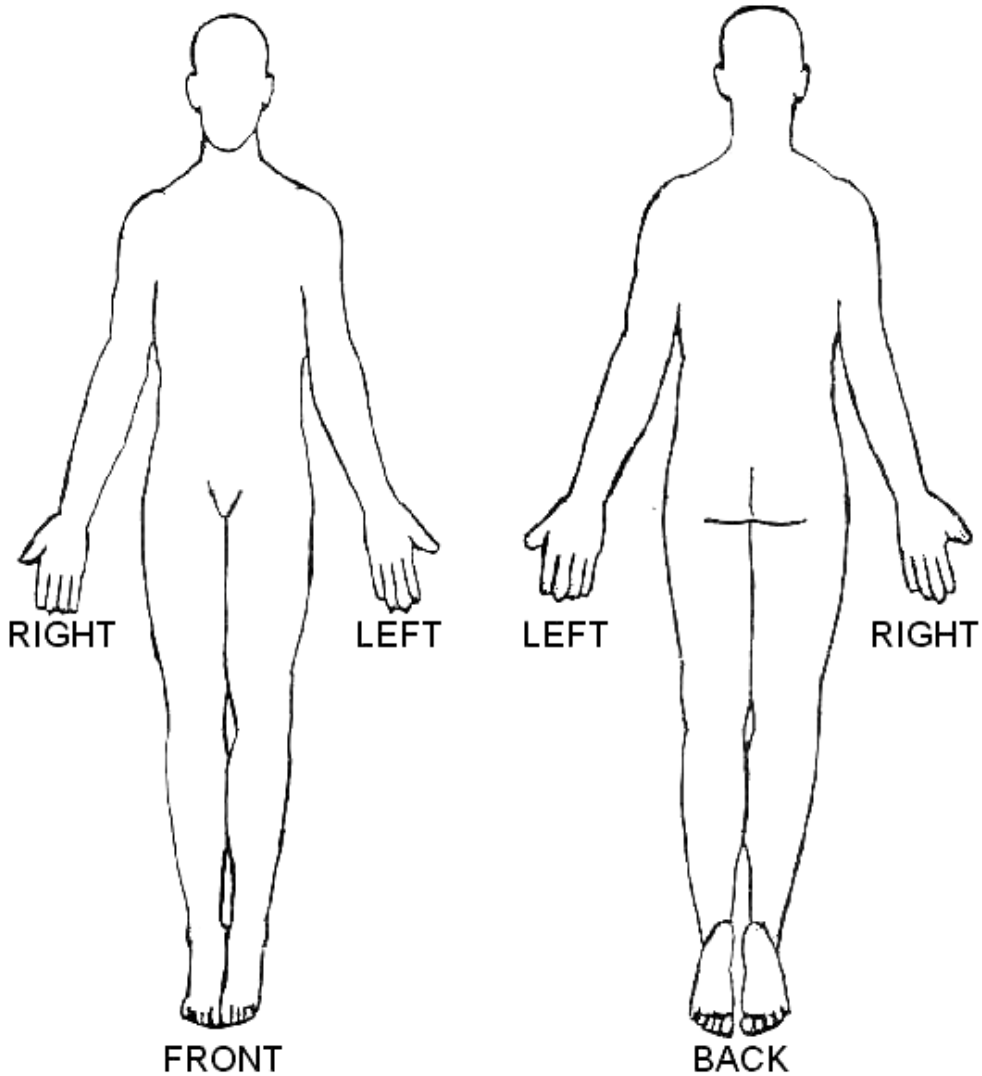
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PAIN EVALUATION PATIENT NAME _____ DATE _____

PAIN DRAWING

Use the symbols below to mark the areas on your body where you feel the following sensations. Include ALL affected areas.

BURNING	NUMBNESS	PINS & NEEDLES	STABBING	ACHE
X	O	=	/	^



Therapist's Signature _____ Date _____

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IMPORTANCE OF KEEPING SCHEDULED VISITS

As a patient at our office, we have the responsibility to provide approved treatment to you per your Doctor's prescription. In many cases, the Doctor's prescription requires you to participate in weekly therapy visits for a specified period of time.

NOTE: All insurance carriers require that a patient receive physical therapy based on a written Doctor's prescription. According to your condition and diagnosis, your physical therapy program was designed uniquely for you by the Physical Therapist. To be sure that the maximum benefit of physical therapy is obtained, the consistency of your visits is very important.

We require that you notify our office 24 hours prior to cancellation of an appointment or there will be a \$50.00 charge which is not covered by your insurance.

**** Children are NOT allowed in the gym area or on any of the gym equipment. They can sit in the waiting room and are allowed in the treatment room with you.**

If you have any questions, please see the front desk.

Patient Signature _____

Date _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The following information is being furnished to you as required under the Standards for Privacy of Individually Identifiable Health Information published by the U.S. Department of Health and Human Services at 45 C.F.R. parts 160 and 164 under the Health Insurance Portability and Accountability Act of 1996. Contact information for the U.S. Department of Health and Human Services is contained at the end of this notice.

1. At New Life Physical Therapy, Inc. (New Life), we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to disclose your health information to those involved in your treatment. For example, we routinely share your continuing progress with your physician, to keep him updated as to your treatment here at New Life.

2. We may use or disclose your health information for payment of your services or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

3. We may use your information to contact you. We may want to call and remind you of appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

4. If this practice is sold, your information will become the property of the new owner. The new owner assumes the accountability for your protected health information.

5. Except as described above, the practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

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6. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

7. You have the right to transfer copies of your health information to another practice. We will make copies available for you to pick up. A nominal fee may be charged for copying or mailing.

8. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

9. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

10. You have the right to receive a copy of this notice.

11. If we change any of the details of this notice, we will notify you of the changes in writing.

12. You may file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC. 20201. You will not be retaliated against for filing a complaint.

13. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Office, Carolyn Cook, at (714) 848-7191.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have read and understand New Life Physical Therapy, Inc. Notice of Privacy Practices.

Signed

Print Name

Date