BAUER PHYSICAL THERAPY
27071 Cabot Rd., #101
Laguna Hills, CA 92653
(949) 588-7278
(949) 588-7331 Fax

Patient Information Sheet

[ ] Cash [ ] Insurance [ ] Medicare
[ ] Personal Injury [ ] Auto Accident [ ] Workers Comp

PATIENT

NAME _____
ADDRESS _____
CITY/ST/ZIP _____
PHONES Home _____ Work _____ Cell _____
EMAIL _____
SS# _____ Date of Birth _____
DRIVERS LICENSE # _____ [ ] Male [ ] Female
Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Life Partner [ ] Separated

EMPLOYER _____ OCCUPATION _____
STATUS [ ] Full-time [ ] Part-time [ ] Unemployed [ ] Disability Return to work date_____

WORKER'S COMPENSATION INSURANCE CARRIER

COMPANY _____ PHONE _____
ADDRESS _____
CITY, STATE, ZIP _____
ADJUSTER _____ PHONE _____
CASE NUMBER _____

INJURY INFORMATION

DATE OF INJURY _____
TYPE OF WORK _____
MAJOR COMPLAINT _____
_____

REFERRING DOCTOR

NAME _____ PHONE _____ FAX _____

EMERGENCY CONTACT

NAME PHONE

AUTHORIZATION

I authorize the release of any medical information necessary to process my claims with the Worker's Compensation carrier above. I hereby Authorize payment of medical benefits Bauer Physical Therapy. I understand that my services must be authorized by worker's compensation..

_____ _____
Signature of Patient Date

Bauer Physical Therapy

MEDICAL HISTORY QUESTIONNAIRE

The following information will be used to establish a physical therapy treatment and fitness program to restore your functional ability. All information is considered confidential and will only be released with your written authorization.

PATIENT NAME: _____

EMAIL: _____
(For internal tracking, billing, progress reports, and direct correspondence only)

What is the primary reason for your visit? _____

Auto accident? Yes No
(If yes, **you** must determine which insurance will cover your care)

Have you previously been treated for this condition? Yes No
If yes, when and by whom?

_____

Have you had surgery related to this condition? Yes No

If yes, type of surgery and when? _____

Rate your pain level currently on a scale of 0 to 10 (0 = no pain): _____

Rate your pain level at the worst time on a scale of 0 to 10 (0 = no pain): _____

Rate your pain level at the best time on a scale of 0 to 10 (0 = no pain): _____

What medications are you presently taking (prescription, over-the-counter, other)?

_____

Have you had any medical problems or hospitalization in the past year? Yes No
If yes, please explain: _____

_____

Surgical History: Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____

Circle all that apply of any problems you have currently or have experienced:

Asthma	Weight Change	Numbness
Arthritis	Nausea / Vomiting	Osteoporosis
Cancer	Gastrointestinal disease	Pregnancy
Chemical dependency	Urinary frequency changes	Planning a pregnancy
Circulatory disease	Visual impairment	Stroke or TIA
Depression	Previous accidents	Thyroid problem
Diabetes	Angina	Tuberculosis
Dizziness	Heart attack	Weakness
Eating disorder	Heart disease	Night pain
Emphysema / COPD / ARDS	Hernia	Allergies
Epilepsy	High blood pressure	Incontinence
Fainting / fatigue	Kidney disease	Sleep dysfunction
Neurological disease	Metal / other implant	Hearing impairment
Headaches	Multiple sclerosis	Fever / chills / sweats
Hepatitis / AIDS	Nervous / anxiety disorder	Back pain
Peripheral vascular disease	History of falls	Balance problems
Seizures	Sensitivity to heat or cold	

Circle all that you are unable to do now due to the onset of your condition:

Sit	Lift 20# or more	Overhead Lift / Reach
Stand up	Prolonged standing	Walk / run
Bend	Grip with hand	Sleep
Dress or bathe	Drive	Walk up or down stairs
Kneel	Bladder control	Feeding yourself

Other (please explain): _____

Circle all the goals you hope to reach from the physical therapy treatment program:

Improved movement	Improved strength
Decreased pain	Improved posture
Improved balance	Increased work ability
Improved home ability	Improved walking
Improved balance	Other: _____

Wellness Survey

How satisfied are you with your overall health / wellness?

Not 0 1 2 3 4 5 6 7 8 9 10 **Very**

How satisfied are you with the way you deal with stress?

Not 0 1 2 3 4 5 6 7 8 9 10 **Very**

How satisfied are you with your nutrition and / or eating habits?

Not 0 1 2 3 4 5 6 7 8 9 10 **Very**

How satisfied are you with your physical fitness level?

Not 0 1 2 3 4 5 6 7 8 9 10 Very

How satisfied are you with your weight?

Not 0 1 2 3 4 5 6 7 8 9 10 **Very**

****

I certify that this information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Evaluating Physical Therapist Signature Date

FINANCIAL AGREEMENT
WORKER'S COMPENSATION

Welcome to ***Bauer Physical Therapy!***

Be assured that you will receive the very best care available for your injury or illness.

Payment Arrangements:
The insurance carrier for your employer, by law, is responsible for payment for your care in our offices. When a person is treated for a condition which is solely the result of an industrial or employment related accident, your worker's compensation insurance will pay for the treatment necessary to restore your health to a pre-injury status, or to a permanent and stationary condition.

Notification of Employer:
When you have suffered a work-related injury or illness, the law requires that you notify your employer within 30 days of your injury. If you do not report your injury, you may be responsible to pay for the charges incurred for your treatment.

Prior Symptoms:
If you are currently experiencing symptoms or problems that you suffered prior to your work-related injury, these may be considered pre-existing conditions or "contributory factors" to your present condition. We will evaluate these symptoms to determine if, and to what extent, these factors are related to your present condition. Once this has been determined, we will notify your worker's compensation insurance carrier to apportion or allocate some part of your care to treatment of those symptoms.

Your Responsibilities:
It is very important for you to follow our recommendations and to keep your scheduled appointments with our offices in order to achieve maximum benefits for your condition. The Worker's Compensation laws state that if you choose not to receive the care that is necessary for treatment of your conditions, your Worker's Compensation benefits will be discounted and your case will be closed, and you will be responsible for payment of services.

Termination of Care:
When your condition has reached "pre-injury status" or is determined to be "permanent and stationary," we will notify you and your physician and prepare a complete discharge summary report.

I have read and agree to the financial policies outlined above.

_____ _____

Signature of Patient ***Date***

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would include sending a bill to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing, cost analysis, and customer service. An example would include internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and aide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

Notice of Privacy Practices (cont…)

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information on HIPAA, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

Bauer Physical Therapy
27071 Cabot Rd., #101, Laguna Hills, CA 92653
(949) 588-7278

I understand that, under the HIPAA of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician communications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____