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

**PATIENT**

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

**PRIMARY INSURANCE INFORMATION**

COMPANY _____ PHONE _____
NAME OF INSURED _____ Date of Birth _____
RELATIONSHIP TO PATIENT _____
EMPLOYER NAME _____
ID # _____ Group # _____
Annual Deductible $_____ Co-Pay $ _____

**SECONDARY INSURANCE INFORMATION**

COMPANY _____ PHONE _____
NAME OF INSURED _____ Date of Birth _____
RELATIONSHIP TO PATIENT _____
EMPLOYER NAME _____
ID # _____ Group # _____
Annual Deductible $_____ Co-Pay $ _____

**REFERRING DOCTOR**

NAME _____ PHONE _____ FAX _____
DATE OF INJURY / ONSET: _____ PRESCRIPTION RECEIVED: [ ] Yes [ ] No

**EMERGENCY CONTACT**

NAME _____ PHONE _____

Who may we thank for referring you? _____
Address / Email _____
_____

**AUTHORIZATION**

I authorize the release of any medical information necessary to process my claims to my insurance company shown above. I hereby Authorize payment of medical benefits due me to Bauer Physical Therapy. I understand that Bauer Physical Therapy will bill my insurance as a courtesy but that I am responsible for the payment of my account if my insurance does not cover the services Rendered to me by Bauer Physical Therapy.

_____ _____
Signature of Patient (Parent/Guardian of Minor) 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 POLICIES

*Welcome to Bauer Physical Therapy!*

*To assist our patients with the most cost-effective treatments, Bauer Physical Therapy is a contracted provider with most major insurance health plans and Medicare. As a contracted provider, we have accepted a discounted rate from your health plan keeping your costs for treatment lower. You are only expected to pay for amounts as quoted by your insurance carrier.*

## Requirements for Patients with Health Insurance or Medicare coverage:

- **You are ultimately responsible for payment for all services rendered**, unless otherwise provided by law.

- **All Co-payments and deductibles** are expected at the time service is rendered. Co-insurance will be sent by statement monthly; payments are due within 30 days.

- A prescription is required from a physician and additional prescriptions if therapy is required beyond the time limit of the current prescription.

- Some insurance carriers require authorization of your treatment. Our office will make these arrangements. Occasionally, there will be a waiting period to receive this authorization. If this occurs, you may request a personalized private pay program so that your therapy progress continues.

- There is an initial comprehensive evaluation fee of **$150**. Your evaluation, along with any treatment received on this initial day, will be billed to your insurance carrier and your payment will be applied to your patient portion.

- All insurance plans will be verified as a courtesy to you. However, patients must understand that charges for services are charged to the patient and not to the insurance company. **If charges billed to your insurance on your behalf are not paid within a reasonable period, the overdue amount becomes your full responsibility and due immediately.** All additional out-of-pocket expenses will be your responsibility.

- If you have a **change of insurance**, please notify our office immediately.

- Equipment purchases are to be paid at the time of purchase. Our office will provide you with an itemized statement of your purchase should you want to submit this to your insurance carrier for reimbursement.

- To cancel or reschedule an appointment, **a minimum 24-hour notice** is required to avoid a **$75 cancellation fee.**

- We accept the following methods of payment: cash, money order, traveler's checks, Visa or Mastercard. There is a **$25 charge** for any returned checks. We do not hold accounts for payment.

- **Auto Accident** – You must notify the Front Desk if your reason for treatment is due to an auto accident. In most cases, your health insurance **will not cover** your treatment and deny payment for services. **You will be responsible for all payments in advance** until any/all liens in the dispute are resolved.

- **Liens and/or Personal Injury** – Bauer Physical Therapy determines acceptance on a case-by-case basis only. We cannot wait for settlements of a pending lawsuit for the payment of services required. We cannot deal with your attorney, or other legal representatives for payment.

***I have read and agree to the financial policies outlined above. I agree to assign insurance benefits to Bauer Physical Therapy whenever necessary. I agree to pay any and all balances due.***

_____ _____

***Signature of Patient (Parent/Guardian)*** ***Date***

_____

***Print Patient Name***

# 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: _____

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## 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: _____