



REBECCA SCHRAVEN, PT
MARIKO EDWARDS, MPT
CHRIS HISAMUNE, PT
RAUL LONA, DPT

PATIENT INFORMATION

PATIENT'S LAST NAME: _____ FIRST NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____
ZIP CODE: _____ HOME PHONE: (____) _____ SOC. SEC. #: _____ - _____ - _____
BIRTHDATE: MO: _____ DAY: _____ YEAR: _____ SEX: M ___ F ___ DRIVER'S LIC #: _____
EMPLOYER: _____ OCCUPATION: _____
WORK PHONE: (____) _____ REFERRING PHYSICIAN: _____
CELL PHONE: (____) _____ E-MAIL ADDRESS: _____

INSURANCE INFORMATION

WHO WILL BE BILLED FOR YOUR THERAPY?

____ Medicare Supplementary Insurance (If Any): _____
____ Private Health Insurer: _____
____ Automobile Insurer: _____ Date of Accident: _____
____ Workers' Compensation: _____ Date of Injury: _____
____ Private Pay (\$125 per evaluation, \$100 per treatment)

HAVE YOU RECEIVED ANY PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY ELSEWHERE THIS YEAR?

____ Yes ____ No

If Yes: Where did you receive this therapy? _____
How many visits did you receive (estimated)? _____

CONTACT INFORMATION

IF THE PATIENT IS A MINOR, PLEASE GIVE NAME AND ADDRESS OF PARENT/LEGAL GUARDIAN:

NAME: _____ PHONE: (____) _____
ADDRESS: _____

PLEASE GIVE NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU:

NAME: _____ PHONE: (____) _____
ADDRESS: _____

Complete the reverse side of this page

WILSHIRE-LINDEN PHYSICAL THERAPY

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Wilshire-Linden Physical Therapy to release any information acquired in the course of evaluation or treatment of the patient to any person or entity which is or may be liable for all or any portion of Wilshire-Linden Physical Therapy's charges. A photocopy of this form shall be deemed as valid as the original.

Signature: _____

NO-SHOW / LATE CANCELLATION FEE

I understand that if I need to cancel an appointment for any reason, I must make every effort to do so within twenty-four hours of my scheduled appointment time. By signing below, I accept that failing to cancel an appointment courteously and promptly will result in a **no-show / late cancellation fee of \$90**, except in the case of sudden illness or extraordinary circumstance. This fee will be billed directly to me, rather than through insurance. A photocopy of this form shall be deemed as valid as the original.

Signature: _____

FINANCIAL AGREEMENT / ASSIGNMENT OF INSURANCE BENEFITS

By signing below, I agree that I am obligated to pay to Wilshire-Linden Physical Therapy all amounts for professional service charges not covered or paid by insurance or third-party reimbursement for same. I further agree that, immediately upon receipt, I shall endorse and deliver to Wilshire-Linden Physical Therapy any and all payments made directly to me by an insurance company or third party on my behalf, as reimbursement for professional charges by Wilshire-Linden Physical Therapy.

I authorize direct payment to Wilshire-Linden Physical Therapy for any insurance benefits otherwise payable for my professional service charges. It is understood that I am financially responsible for charges not covered by this agreement. I also understand that failure to address my financial responsibilities can result in my case being sent into Collections. A photocopy of this form shall be deemed as valid as the original.

Date: _____

Signature: _____



PHYSICAL THERAPY

9701 Wilshire Boulevard
Mezzanine Level
Beverly Hills, CA 90212
Phone: 310/275-4137
Fax: 310/274-1815
E-mail: w-lpt@w-lpt.com

PATIENT HISTORY FORM

Name _____ Sex _____ Date of Birth _____

Please complete all requested information. Use reverse side if needed for additional space.

1. Have you ever had any of the following? (For any YES answer, explain in the lines at right)

High blood pressure	NO	YES	_____
Heart trouble	NO	YES	_____
Circulation trouble	NO	YES	_____
Dizzy spells	NO	YES	_____
Diabetes	NO	YES	_____
Other Illness	NO	YES	_____

Any surgery? NO YES _____
(if yes, give dates, operations, and outcomes)

2. Do you have any of the following?

Metal anywhere in your body? (Other than your teeth)	NO	YES
A cardiac pacemaker?	NO	YES
An IUD?	NO	YES

3. (For women only) Are you pregnant? NO YES

Date of your last menstrual period: _____

4. Do you have trouble with:

Vision	NO	YES	Hearing	NO	YES
Allergies	NO	YES (if yes, describe):	_____		

5. List any medications you're now taking: _____

6. Have you ever had physical therapy before? NO YES
If Yes, when, where, and for what problem? _____

7. Describe the history of your present pain. _____

Date: _____

Signature: _____

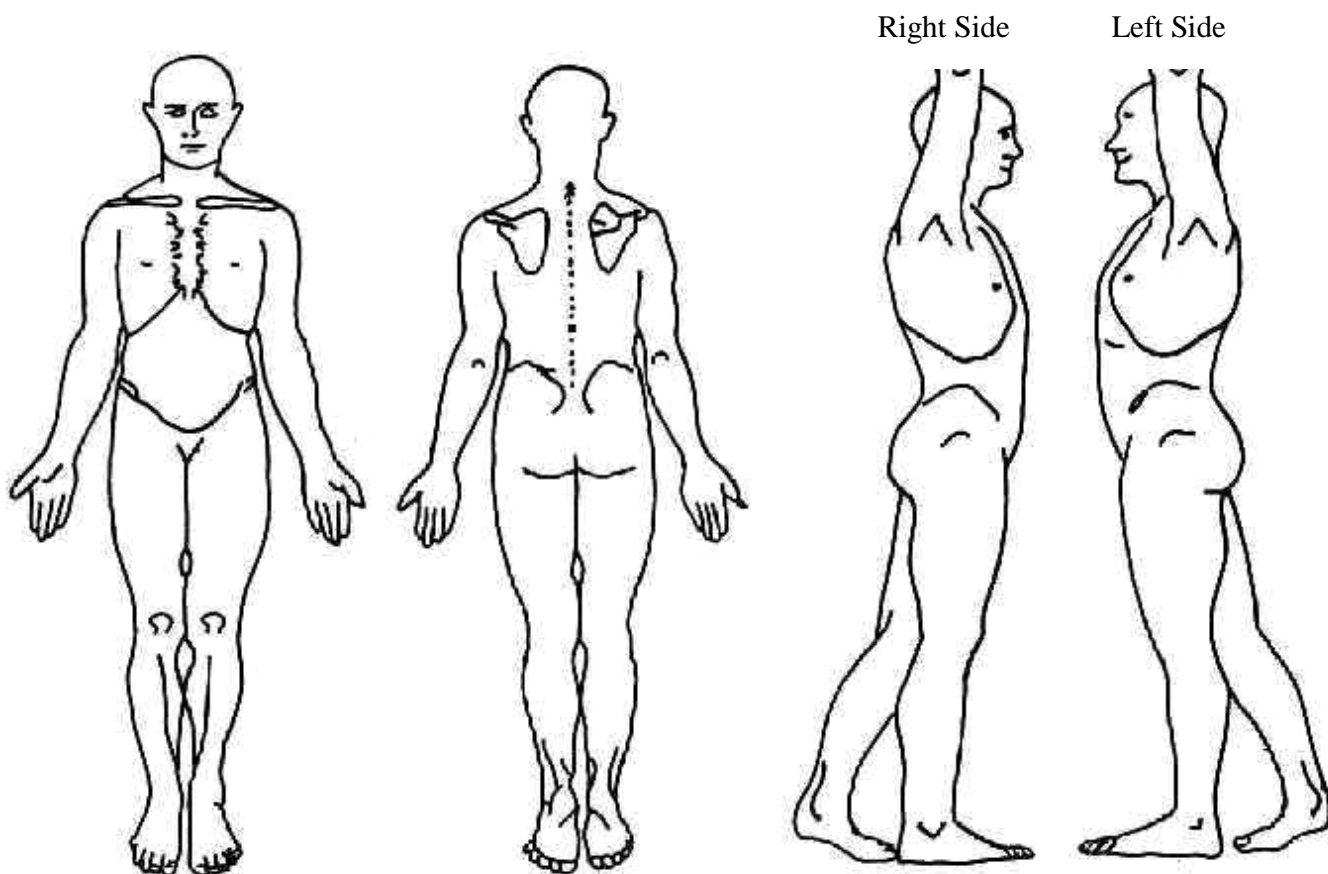


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Where is your pain?

Please mark on the drawings below the areas where your pain is located.



Circle the number that best corresponds to the level of your pain.

0	1	2	3	4	5	6	7	8	9	10
NO HURT		HURTS LITTLE BIT		HURTS LITTLE MORE		HURTS EVEN MORE		HURTS WHOLE LOT		HURTS WORST

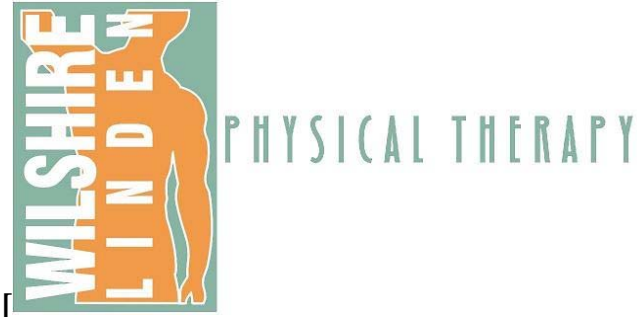
Name: _____ Date: _____

2011 Medicare Cap on Therapy Services

Home Health Services & Outpatient Therapy	
Beneficiaries receiving ANY type of home health services are ineligible for outpatient physical therapy.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you currently receiving ANY home health services?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you received ANY home health services (nursing, therapy, etc.) in the last six months? If YES, indicate date the services ended:

2011 Therapy Cap Summary	
<p>Medicare has placed a financial limitation of \$1,870 on the amount of therapy an individual can receive in 2011. This cap combines physical therapy and speech-language pathology services for dates of service from January 1, 2011 through December 31, 2011. The cap excludes services provided at hospitals. The cap is based on the Medicare allowed fees.</p> <p>If you get close to reaching the cap, we will review the available options with you. Medicare has defined automatic and manual exceptions. We will inform you if you appear to be eligible for an exception and will institute the appropriate steps with Medicare.</p> <p>We believe that continuity of care is critical to reaching maximum function and returning you to an active lifestyle. Therefore, we have developed special programs to assist our patients that have reached the cap in continuing care here at Wilshire-Linden Physical Therapy. We will keep you informed about your options.</p>	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you received ANY outpatient physical therapy services since January 1, 2011? If YES, indicate: Where: When:
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you received ANY speech-language pathology services since January 1, 2011? If YES, indicate: Where: When:

Signature	
My signature below indicates that I have read and understand the above information regarding the Medicare Therapy Cap and have had all my questions answered.	
Signature:	Date:



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Fax: (310) 274-1815

NOTICE OF PRIVACY PRACTICES

We protect the privacy of our patient's health information as required by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

Your Health Information

THIS NOTICE DESCRIBES YOUR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We collect, use, and disclose information provided by and about you for medically necessary treatment, health care payment and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required by Law: Information provided by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other used and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights

Under regulations that will be in effect on April 14, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact our privacy officer at:_____.

Declaration of Privacy of Health Information

All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Further, I authorize that the results of any assessments or records given to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors, and administrators.

Restrictions requested by patient:

Signature of Patient:_____Date:_____