Body Basics Physical Therapy – Medical History

Name _____ Date _____

Age _____ Height _____ Weight _____ Hand Dominance: ○ Right ○ Left

Primary Language _____ Do you require an interpreter? ○ Yes ○ No

How did you hear about us? _____

Doctor's First and Last Name: _____ Office location: _____

Describe the pain or problem(s) for which you seek physical therapy:

_____

_____

What happened? _____

When did this happen or start? (date) _____

Since onset, the problem is: (choose one) ○ improving ○ stable ○ worsening

Have you ever had the problem(s) before? ○ Yes ○ No _____

Have you seen anyone else for the problem(s)? ○ Yes ○ No _____

Have you had any of the following tests done: ☐ X-rays ☐ MRI ☐ CT Scan ☐ Ultrasound

☐ Blood Tests ☐ EMG ☐ Nerve Conduction Test ☐ EKG ☐ Stress Test (e.g. treadmill test)

How often do you have pain? ○ Constant ○ Periodic/Intermittent ○ Brief/Momentary

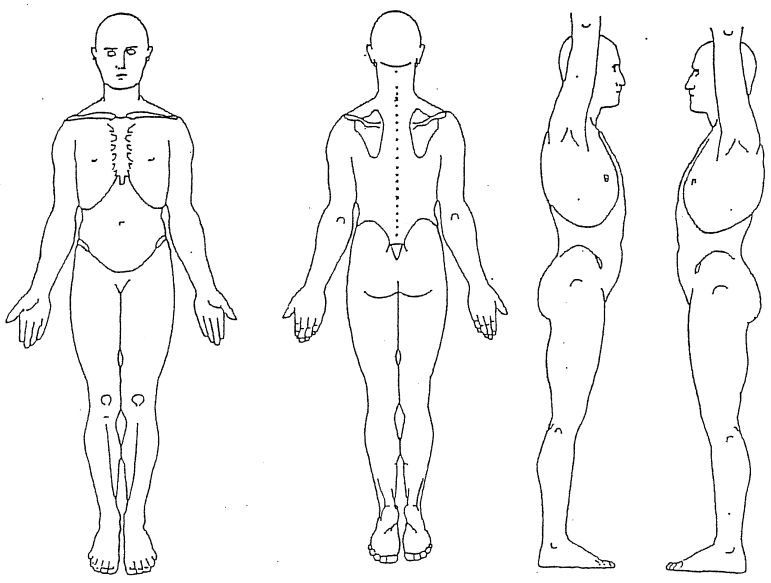
When is it worst: ☐ Morning ☐ Mid Day ☐ Afternoon ☐ Evening ☐ Sleeping

What makes the pain/problem better? _____

What makes the pain/problem worse? _____

What do you have difficulty doing? _____

Indicate on the body diagrams where your symptoms are located:



Current Pain Level

0 1 2 3 4 5 6 7 8 9 10

None Worst

Least Pain Level

0 1 2 3 4 5 6 7 8 9 10

None Worst

Worst Pain Level

0 1 2 3 4 5 6 7 8 9 10

None Worst

Have you ever had any of the following?(check all that apply)

- ☐ Heart problems/angina/chest pain
- ☐ Device, pacemaker or defibrillator in your body
- ☐ High or low blood pressure
- ☐ Blood clots
- ☐ Peripheral vascular disease
- ☐ Stroke or brain injury
- ☐ Epilepsy/seizures
- ☐ Multiple sclerosis
- ☐ Lung problems
- ☐ Asthma
- ☐ Kidney/urinary tract problems
- ☐ Stomach or intestinal problems
- ☐ Liver problems
- ☐ Gynecological problems
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Loss, impairment or transplant of any organs
- ☐ Major sprains/strains
- ☐ Fractures/broken bones
- ☐ Arthritis (Osteoarthritis)
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Autoimmune disease
- ☐ Genetic disorder
- ☐ Diabetes
- ☐ Gout
- ☐ Tuberculosis
- ☐ Fibromyalgia
- ☐ Visual/hearing impairment
- ☐ Allergies (ex tape, latex, creams)
- ☐ Anxiety/panic attacks
- ☐ Neurological disorders
- ☐ Hepatitis/HIV/AIDS
- ☐ Tobacco/smoking (amount/wk)
- ☐ Two or more falls in the past 12 months or 1 fall in the past 12 months resulting in injury?

Have you had any of the following in the past 4 weeks? (check all that apply)

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Loss of appetite
- ☐ Fever/chills/sweats
- ☐ Changes in bowel/bladder function
- ☐ Alcohol (drinks/wk)
- ☐ Skin disease/rash
- ☐ Fatigue/Weakness
- ☐ Anemia
- ☐ Heartburn/Indigestion/ulcer
- ☐ Coordination problems
- ☐ Dizziness/vertigo/lightheaded
- ☐ Depression
- ☐ Weight loss/gain
- ☐ Fainting/drop attacks
- ☐ Current Pregnancy
- ☐ Swelling in legs
- ☐ Injections
- ☐ Headaches
- ☐ Recent infection/illness

Please list all hospitalizations/surgeries/procedures you have had with dates (including elective surgeries):

Name of medication/vitamin/herb	Dose	Frequency	Oral/Injection/Topical

Describe your regular exercise routine including any recreational activities/sports:

_____

Occupation _____ Employer _____

What are your goals for physical therapy? _____

Please list an emergency contact with phone number:_____

I have not omitted any relevant medical conditions or history _____
Signature

Body Basics Physical Therapy

Informed Consent

I hereby give BodyBasics Physical Therapy my consent for evaluation and treatment of my physical condition for physical therapy services. I certify that I have fully disclosed my medical history.

Treatment may include postural instruction, gait and ergonomic training, soft tissue and joint mobilization/manipulation, stretching, exercise, neuromuscular re-education, education on my dysfunctions and/or disease processes, ice, heat, electrical stimulation, ultrasound, paraffin, whirlpool, traction, taping, bracing and orthotics. I understand that I can at any time withdraw my consent to any of the treatments offered me.

I understand that there is a minor risk of injury or increased pain with the above treatments. If I experience any problems with treatment or evaluation other than temporary soreness, I will inform my therapist promptly.

I understand that no guarantee can be given as to the outcome of these services.

I certify that I have read and understand this informed consent, and that I have asked all questions and received answers to my satisfaction.

Signed

_____	_____	_____	_____
Patient	Date	Witness	Date

Notification of Privacy Practices

I have received a copy of "Notice of Privacy Practices".

Signed,

_____	_____
Patient	Date

Body Basics Physical Therapy

Billing Policy, Release, and Authorization

I authorize BodyBasics Physical Therapy, Inc. to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to BodyBasics Physical Therapy, Inc. I authorize BodyBasics Physical Therapy to release medical or other information necessary to process this claim. I understand that BodyBasics Physical Therapy is billing my insurance company as a courtesy and that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

I understand payment in full is due when services are rendered (not when an invoice has been mailed) unless prior arrangements have been made. I will receive an invoice in the mail approximately every 15 days after the initial day of service. If a collections company is involved in collecting my balance, I am aware that I am responsible for collections and/or attorney's fees. Late or partial payments do not constitute a waiver of this agreement.

Charges: Most physical therapy charges are determined by types of procedures performed or time spent in treatment (rounded to the nearest 15 minutes).

Returned Checks: returned checks will incur a $25.00 fee.

I understand the policies above.

Signature: _____ Date: _____

No-Show, Cancellation Policy

I understand I must give 24 hours notice if I am going to miss my appointment. If I fail to notify the office 24 hours in advance, I will be charged a $20.00 fee.

Signature: _____ Date: _____

Notice of Privacy Practices

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

1) Uses and Disclosures we will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) **Your Privacy Rights**

Restrictions
You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Requested restrictions must be in writing and submitted to the privacy officer before an agreement is reached.

Confidential Communications
You have the right to request confidential communication from us at a location or mode of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to revise this policy as needed at a future date.

Body Basics Physical Therapy
2275 S Main St. Suite 102
Corona, CA 92882

Privacy Contact
If you would like more information about our privacy practices or to file a complaint you may contact: Scott Hunsaker, Privacy Officer
2275 S Main St. Suite 102
Corona, CA 92882
(951) 273-7742

Effective Date: This Notice will take effect on April 14, 2003