Ortho Pro Physical Therapy

Last name: _____ First: _____ Middle Init.: _____ Sex: M / F

Birth Date: _____ Marital Status: _____ Occupation: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home ph: ( )_____ Work ph.: ( )_____ Cell ph: ( )_____

Email: _____ Driver's Lic: _____ Soc Sec # : _____

Employer: _____ Address: _____

Nearest friend or relative: _____ City: _____ Ph: _____

How were you referred _____

Area of Pain: _____ Date of Injury/When Symptoms Began:_____

Patients Signature: _____ ***Date:*** _____

Medical Insurance Information ***Please allow us to make a copy of your card***

Primary cardholder name: _____ ***Date of Birth***: _____

Is your injury or problem due to a work injury or accident? Yes / No _____

_____ _____(Initial and date) I have been informed as to my Physical Therapy benefits and understand it is my responsibility to pay for non paid deductibles, co-pays and other fees that my insurance will not pay. I understand that OPPT has obtained my benefits information to the best of their ability and it is my responsibility to ultimately verify my insurance benefits.

FOR OFFICE USE ONLY:

Deductible: _____ ***Met:*** _____

% Patient's insurance will cover, ONCE deductible is met: _____

# of visits allowed per year: _____ ***Co-pay:*** _____ ***Rx:*** _____

Entered in WebPT _____ Scanned Forms (Intake, ins, etc.) _____ Forms in WebPT _____

Ins benefits Pt. _____

Patient History Form

Name: _____ Sex: M / F Age: _____ Height: ____ft ____in Weight: _____

1. Are you currently working? ___Yes ___ No (last day worked: _____)
2. Please give your occupation and physical demands: _____

_____

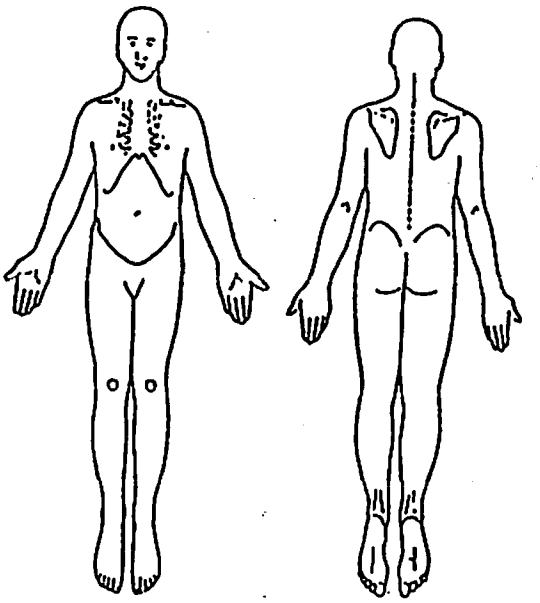
3. List your complaints or problems _____

_____

4. Please rate your level of pain between 1 – 10.

   1 2 3 4 5 6 7 8 9 10
   mild moderate extreme pain

5. Please indicate painful areas by shading the models to the right:



6. Which of the following describes your pain: (circle all that apply)

   Sharp Dull Aching Tingling
   Numb Constant Variable Radiating

7. How did your problem start?

_____

_____

8. Are there any positions or activities that make your pain worse? _____

_____

9. Are there any positions or activities that lessen your pain? _____

_____

10. Please list any medication(s) you are taking for this problem: _____

_____

11. What tests or treatment have you received for this problem? _____

_____

Past Medical History

12. Have you ever had any of the following?

Heart / Vascular Disease	Yes/No
Congestive Heart Failure	____
High Blood Pressure / Hypertension	____
Heart Attacks	____
Stroke / TIA	____
Pacemaker	____
Atherosclerotic Disease (CAD)	____
Angioplasty	____
Valve Disease	____
Arrythmia	____
Bypass Graft (CABG)	____
Atherosclerotic Disease (CAD)	____
Angioplasty	____
Valve Disease	____
Arrythmia	____
Angina	____

Lung Disease	Yes/No
Chronic Obstructive Disease (COPD)	____
Recent Pneumonia	____
Asthma	____
Acquired Respiratory Distress Syndrome	____
Emphysema	____

General Medical Conditions	Yes/No
Arthritis (rheumatoid/osteo)	____
Allergies	____
Neurological Conditions (MS, Parkinson's, etc)	____
Headaches	____
Gastrointestinal Disease (ulcers, hernia, IBS, Crohns, liver/gall bladder)	____
Visual Impairments	____
Back Pain (neck, back, disc disease, etc)	____
Hepatitis	____
HIV / AIDS	____
Osteoporosis	____
Depression	____
Kidney / Bladder / Prostate Issues	____
Incontinence	____
Hearing Impairments	____
Sleep Dysfunction	____
Prosthesis	____
Implants (metal, etc)	____
Cancer (active/remission)	____
Diabetes	____
Previous Surgeries (please write down)	____

13. Do you have metal anywhere in your body (other than teeth)? If so, where? _____

14. Are you pregnant? If yes, how many weeks/months? _____

15. List all allergies you have: _____

16. Have you ever had physical therapy treatments? If yes, when and for what? _____

17. Have you had any physical/occupational/chiropractic/speech therapy this year? If yes, how many treatments? _____

(Other therapies this year may limit your allowed number of PT visits with us)

To the best of my knowledge, the stated medical information is true and correct.

Date:_____ Signature:_____

Ortho Pro Physical Therapy

AUTHORIZATION TO PAY PHYSICAL THERAPY PROVIDER / FINANCIAL AGREEMENT

I hereby authorize Ortho Pro PT / Jeff Waldberg, PT MOMT to charge my insurance company for services rendered including, but not limited to, manual therapy, modalities for pain management, and therapeutic exercise for flexibility and strengthening. I further authorize Ortho Pro PT / Jeff Waldberg, PT MOMT to furnish my insurance company my treatment records upon request.

I authorize and instruct _____ insurance company to pay for my services by payment going to:

Ortho Pro Physical Therapy or Jeff Waldberg, PT MOMT
1145 Lindero Canyon Rd. #D7
Westlake Village, CA. 91367

Please read the following and sign below.

1. This payment will not excuse my indebtedness to Ortho Pro PT / Jeff Waldberg PT MOMT

2. I understand that my insurance will on average be billed weekly. I agree that if my insurance does not pay within 60 days of being billed that it will then be my responsibility to make payment on any outstanding balance due.

   Ortho Pro Pt's policy is to collect fees pertaining to deductibles, co-insurance and percentages, plus any additional fees for which I am responsible for. I may make payments on my portion due or pay it in full. However, the balance for which I am responsible for is due by the end of my treatment sessions.

   Medical Deductible: _____

3. I agree that any balance of said charges over and above those which have been paid by my insurance will be paid by me.

4. I agree that charges that are past due over 90 days will incur a finance charge of 5% of the unpaid balance. I understand and agree that balances past 120 days will be turned over to a collection, and any additional collection fees and finance charges will be paid by me.

5. I understand that there is a $25 fee for cancellations made on day of my set appointments. I also understand that there is a $25 fee for failure to show for any scheduled appointments. I acknowledge that this $25 fee, if accrued, is to be paid by me, separate from charges made by my insurance.

Date: _____ Patients Signature _____

Ortho Pro Physical Therapy

CONSENT TO TREAT

I, _____, hereby consent to routine Physical Therapy services as provided by Ortho Pro Physical Therapy & Jeff Waldberg, PT MOMT and his staff under his supervision. This will be done according to the general instructions of the referring physician (if applicable). I acknowledge that the treatment may include any number of modalities and/or procedures that will be rendered according to the general guidelines of my physician (if applicable) and the physical therapist.

Date: _____ Patients Signature: _____

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.

Uses and Disclosure of Your Medical Information

For Treatment: we may use medical information about you to provide you with medical treatment or services.
For Payment: We may use/disclose medical information about you so that the treatment/services you receive by us may be billed to and payment may be collected from you, an insurance company or a third party.
For Health Care Operation: We may use and disclose health information about you for operations of our practice.
For Individuals Involved In Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved with your care.
For Health Related Services and Treatment Alternatives: *We may use and disclose health information to tell you about health-related* services or recommend possible treatment options or alternatives that may be of interest to you.
As required by law: We will disclose medical information about you when required by federal, state or local law.
To Avert a Serious Threat to Health & Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
For Military or Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
For Workers Compensation: We may use and disclose health information about you for Workers Compensation or similar programs.
For Public Health Risks: We may use and disclose health information about you for public health activities.
For Health Oversight Activities: We may use and disclose health information about you to a health oversight agency for activities authorized by law
For Lawsuits and disputes: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order.
For Law Enforcement: *We may release medical information if asked to do so by law enforcement officials.*
For Coroners, Medical Examiners: We may release medical information to a coroner or medical examiner.
For National Security and Intelligence Activities: We may use and disclose health information about you for intelligence, counterintelligence, and other national security activities authorized by law.
For Protective Services for the President and Others: We may use and disclose health information about you authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Your Rights Regarding Your Medical Information

Your Right to Inspect and Copy: To inspect and or copy your medical records you must submit a request in writing.
In limited situations we may deny your request to inspect and copy. If you are denied access to medical information, you may request in writing that denial be reviewed.
Your Right to Amend: If you feel that medical information we about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.
Your Right to an Accounting of Disclosures: You have the right to rquest in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations as previously described.
Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclosed about you for treatment, payment, or health care operations. ***We are not required to agree to your request.***
Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.
Your Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time.

Changes to This Notice: We reserve the right to change this notice, and will post the current notice in our facility
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health & Human Services.
Other Uses of Medical Information: Other uses and disclosure of medical information not covered by this notice or the laws that apply to *us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may* revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

By my signature I acknowledge receipt of a copy of the Notice of Privacy Practices

X _____ X _____

Patient or Patient Representative Signature ***Date***