POSITIVE PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES
Effective: February 2014

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

POSITIVE PHYSICAL THERAPY'S LEGAL DUTY

Positive Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Positive Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

Positive Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Positive Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Positive Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our notice of the information practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstances. Positive Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Positive Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. First further information on Positive Physical Therapy's health information practices, or if you have a complaint, please contact the following:

Positive Physical Therapy
12203 Santa Monica Blvd.
Los Angeles, CA 90025
(310) 770- 7586

PATIENT NAME: ____ DATE: _______________

PATIENT SIGNATURE: ____

MEDICAL TREATMENT CONSENT

The information provided is true to the best of my knowledge. I hereby agree and give my consent to medical treatment in treating my physical condition. I authorized release of any medical information needed to process my claim. Positive Physical Therapy will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nevertheless, it is ultimately your responsibility to understand your policy, its benefits, and the obligations it places on you. It is not the responsibility of Positive Physical Therapy to verify your insurance coverage or determine which services are or are not covered. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to informed the office of any changes that occur. I authorize release of payment directly to Positive Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection cost that are incurred.

CANCELLATION POLICY

If you cannot make your appointment, we require a 24-hour notice.

If you do not show up to your appointment or do not notify our office 24 hours prior to your scheduled appointment, you will be responsible for a **$75 Fee**.

If you do need to cancel and appointment, please call or email our office at:
(310) 770- 7586 or through **positiveptbody@gmail.com**

By signing this contract, you are agreeing to the terms above.

PATIENT NAME: ____ DATE: ________________

PATIENT SIGNATURE: ____

NAME: ______________________ **DATE OF BIRTH**: ___________ **SSN**: ___________

EMAIL: ____________________________ **PHONE**: __________________

HOME ADDRESS: ______________________________________

CITY/STATE: _________________ **ZIP CODE**: ___________

EMERGENCY CONTACT: __________________ **EMERGENCY PHONE**: ___________

During the past month, have you been feeling down, depressed, or hopeless? YES NO
During the past month, have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Have you EVER been diagnosed as having any of the following conditions?

☐ Yes	☐ No	Anemia	☐ Yes	☐ No	High blood pressure
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Incontinence
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Disease If yes, what kind: ________
☐ Yes	☐ No	Autoimmune Disease If yes, what kind: ________	☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Blood Clots/ Emboli	☐ Yes	☐ No	Multiple Sclerosis
☐ Yes	☐ No	Cancer/ Chemo/ Radiation If yes, what kind: ________	☐ Yes	☐ No	Osteoporosis/ Osteopenia
☐ Yes	☐ No	Chemical dependency (IE: alcoholism)	☐ Yes	☐ No	Other: ______________
☐ Yes	☐ No	Circulation problems	☐ Yes	☐ No	Rheumatoid Arthritis
☐ Yes	☐ No	Crohn's Disease	☐ Yes	☐ No	Sexually Transmitted Disease
☐ Yes	☐ No	Depression	☐ Yes	☐ No	Stomach ulcers
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Stroke/ TIA
☐ Yes	☐ No	Epilepsy/ Seizures	☐ Yes	☐ No	Thyroid problems
☐ Yes	☐ No	Heart problems If yes, what kind: ________	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Varicose veins

Please list any medications, vitamins, and/or supplements you are currently taking (prescription and nonprescription) and include dosage and frequency:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

How many packs do you smoke per day? _____ for how many years? _____ If quit, when? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON	DATE	REASON
________	________________	________	________________
________	________________	________	________________

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	REASON	DATE	REASON
________	________________	________	________________
________	________________	________	________________

Referring MD: ___________________________

Do you have a Physical Therapy referral/ prescription? YES NO

Please check any of the following whose care you are under:

_____ Medical Doctor (MD) _____ Psychiatrist/ Psychologist _____ Orthopedic Specialist

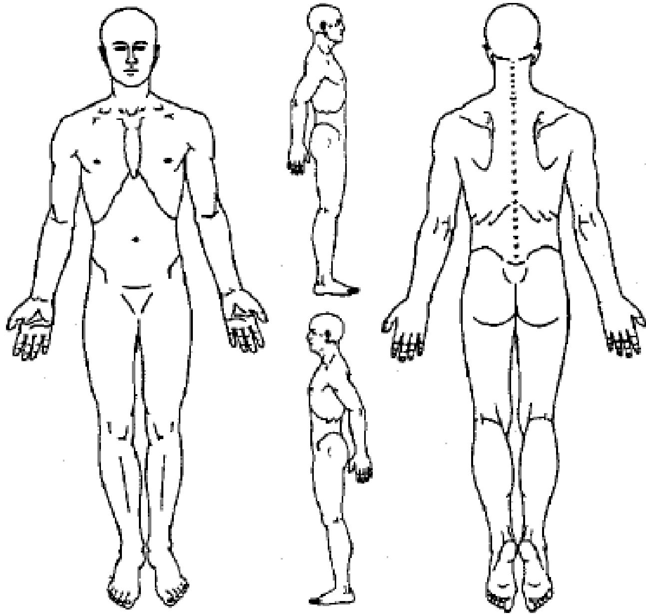
_____ Osteopath (DO) _____ Physical Therapist _____ Other

_____ Dentist _____ Chiropractor

Have you had any of the following diagnostic tests recently?

☐ Yes ☐ No MRI ☐ Yes ☐ No X-Ray ☐ Yes ☐ No Other: __________

☐ Yes ☐ No CT Scan ☐ Yes ☐ No EMG



Date of Injury: __________________________

Reason for Physical Therapy visit?

____

____

____

Pain scale: 0= no pain, 10=unbearable pain, must go to the hospital

The worst pain felt: ____/10

The best it feels: ____/10

Currently, my pain is: ____/10

Do you experience any of the following?

☐ Yes ☐ No Abdominal Pain

☐ Yes ☐ No Arm/ Leg Swelling

☐ Yes ☐ No Blood in Stools/ Urine

☐ Yes ☐ No Constipation/ Diarrhea

☐ Yes ☐ No Difficulty Breathing

☐ Yes ☐ No Difficulty Swallowing

☐ Yes ☐ No Dizziness/ Lightheadedness

☐ Yes ☐ No Double Vision

☐ Yes ☐ No Easy Bruising

☐ Yes ☐ No Excessive Bleeding

☐ Yes ☐ No Eye Redness

☐ Yes ☐ No Fainting

☐ Yes ☐ No Falling/ Balance/ Coordination Problems
When was the last fall? ______________

☐ Yes ☐ No Fatigue

☐ Yes ☐ No Fever/ Chills/ Sweats

☐ Yes ☐ No Hearing Problems

☐ Yes ☐ No Heartburn/ Indigestion

☐ Yes ☐ No Loss of Vision

☐ Yes ☐ No Nausea/ Vomiting

☐ Yes ☐ No Night Sweats

☐ Yes ☐ No Numbness/ Tingling

☐ Yes ☐ No Pregnant or think you might be pregnant

☐ Yes ☐ No Problems Sleeping

☐ Yes ☐ No Problems Urinating/ Incontinence

☐ Yes ☐ No Pulsating sensation in abdomen

☐ Yes ☐ No Regular Cough

☐ Yes ☐ No Sexual Difficulties

☐ Yes ☐ No Shortness of Breath/ Chest Pain

☐ Yes ☐ No Skin Rash

☐ Yes ☐ No Sudden Weakness

☐ Yes ☐ No Tremors

☐ Yes ☐ No Unexplained Joint/ Muscle Swelling

☐ Yes ☐ No Unusual stress at home or work

☐ Yes ☐ No Weight Loss/ Gain