



MEDICAL HISTORY QUESTIONNAIRE

CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Check if you would prefer **not** to receive emails with information regarding your Empower PTAI experience, weekly health tips, or exciting periodic happenings at Empower PTAI.

Date of Birth: _____

Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

COURTESY REMINDERS

Select one of the following to receive courtesy reminder emails OR texts (choose ONE):

Email Text - Please list carrier below:

Standard text msg rates may apply. By checking one of these boxes, you are consenting to receive automatic reminders for appointments.

EMERGENCY CONTACT

Last Name: _____

First Name: _____

Relationship: _____

Phone: _____

EMPLOYER INFORMATION

Occupation: _____

Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

HOW DID YOU HEAR ABOUT Empower PTAI?

Please select ALL that apply:

Doctor: _____

Family or Friend: _____

(Please include full name)

Insurance: _____

Internet Search: _____

Other: _____

REFERRING DOCTOR

Name of Doctor who referred you: _____ Date of follow up visit with this Doctor: _____

This date is needed to send a progress report before your appointment.

CASE INFORMATION

Have you been a patient here before? Yes No

WORK related injury? Yes No (If yes, please provide the employer where the injury occurred in the employer section above)

AUTO related injury? Yes No (If yes, please provide the amount of medical payment your auto insurance will cover)

SPORTS related injury? Yes No (If yes School: _____ Sport: _____)

DESCRIPTION OF SYMPTOMS

Date of Injury or Onset of Symptoms: _____

Type of Surgery / Date (if applicable): _____

Describe how your injury occurred or when/how your symptoms began:

Current complaint:

What activities would you do different if you did not have pain?

What prescription medications are you taking (if any) for this condition?

Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis (rheumatoid /osteoarthritis) | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Previous Accidents |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Types I and II | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema | <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Anxiety or Panic Disorders |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Visual Impairment (such as cataracts, glaucoma, macular degeneration) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Congestive Heart Failure (or heart disease) | <input type="checkbox"/> Hearing Impairment (very hard of hearing, even with hearing aids) | <input type="checkbox"/> Other Disorders |
| <input type="checkbox"/> Heart Attack (Myocardial infarction) | <input type="checkbox"/> Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) | <input type="checkbox"/> Hepatitis / AIDS |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney, Bladder, Prostate, or Urination Problems | <input type="checkbox"/> Prior Surgery |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) | | <input type="checkbox"/> Prosthesis / Implants |
| <input type="checkbox"/> Stroke or TIA | | <input type="checkbox"/> Sleep Dysfunction |
| | | <input type="checkbox"/> Injections for Your Current Problem |
| | | <input type="checkbox"/> Pacemaker |
| | | <input type="checkbox"/> Metal Implants |
| | | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Smoking |



CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____, hereby consent to the therapeutic procedures outlined below, to be performed by Empower Physical Therapy & Aquatics Institute and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Empower Physical Therapy & Aquatics Institute or from any other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature: _____ Date: _____

Physical Therapist's Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through Empower PTAI's billing department. These arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Empower Physical Therapy & Aquatics Institute I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED, THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO THE SERVICES PROVIDED. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.

Although I have requested Empower Physical Therapy & Aquatics Institute to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO EMPOWER PHYSICAL THERAPY & AQUATICS INSTITUTE FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM.

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent/Authorized Representative: _____ Date: _____
(If applicable)

EMPOWER PHYSICAL THERAPY & AQUATICS INSTITUTE PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of a person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____ Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physical Therapist or Authorized Representative's Signature Date

By: _____
Patient's or Patient Representative's Signature Date

Empower Physical Therapy & Aquatics Institute
Print or Stamp Name of Physical Therapist, Medical Group or Association

By: _____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.



PATIENT COMMITMENT & MISSED APPOINTMENT POLICY

OUR COMMITMENT TO YOU

Our team is passionately committed to providing the highest quality of care and service to help you return to life without pain or limitation. We focus on treating you (not just your injury) and are devoted to providing a compassionate, healing environment for you to thrive and accomplish your goals.

YOUR COMMITMENT TO PHYSICAL THERAPY

It is expected that you keep all your scheduled appointments. Our physical therapists will prescribe a frequency that will help you toward achieving your goals. Adhering to the recommended number of treatments is an essential component of your progress and we have established the following policy in order to ensure optimum results for you.

24-Hour Cancellation Policy

A 24-hour notice is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

In an instance of a cancellation without 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge a \$50 fee.

If there's an emergency, we understand and can make an exception. In the case of repeated cancellations, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation frequency.

I certify that I have read and understood the above policy.

Patient's Name: _____

Patient's Signature: _____ Date: _____



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SUMMARY OF NOTICE OF PRIVATE PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information

We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members to close friends who are involved in your health care;
- For certain limited research purposes; For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities; To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product deficits or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information; To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information; To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

HIPAA Contact: Bobby Hamidi (949) 939-8198



Coronavirus Disease 2019 Questionnaire

This Information is Highly Confidential & Will be Securely Managed

Name: _____ Date: _____

You will be asked to complete this form at each visit or to verbally confirm that there have been no changes in your answers since the initial form completion. Employees will attest to absence of symptoms twice a day.

Please check the **Yes** or **No** boxes; do not check both boxes. Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you traveled outside this city or town in the past 30 days? Yes No
If yes, please list the countries, states or towns you have visited below.
Comment: _____

2. Have you been in close contact with an individual who has traveled outside of this city or town in the past 30 days? Yes No
If yes, please list the countries, states or towns he/she has visited below.
Comment: _____

3. Have you been in close contact, in the past 14 days, with an individual who has had any of the first three symptoms or a combination of one of the first three and another symptom listed?

- | | |
|--|--|
| <input type="checkbox"/> Fever over 100.4° | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Persistent cough | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Shortness of breath | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Fatigue | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Anorexia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Sputum production | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Myalgia | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes, have they been diagnosed and/or seen the doctor? Yes No

4. Have you had any these symptoms, in the past 14 days or had any of the first three symptoms or a combination of one of the first three and another symptom listed?

- | | |
|--|--|
| <input type="checkbox"/> Fever over 100.4° | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Persistent cough | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Shortness of breath | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Fatigue | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Anorexia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Sputum production | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Myalgia | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes, how long have you had these symptoms? _____
If yes, have you been diagnosed and/or seen the doctor? Yes No

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability; if you are a provider we will enforce work restrictions as indicated by the CDC or your personal physician.

Please contact us at (949) 545-7007 if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.



Credit Card Authorization

At our medical practice, we strive to provide the highest quality care to our patients. In order to streamline our billing process and ensure that we can deliver the best care possible, we request that you provide us with a valid credit card to keep on file.

This credit card will only be used for charges that are not covered by your insurance policy. This may include co-payments, deductibles, non-covered services, or any outstanding balances.

Please be assured that we take your privacy and security seriously. Your credit card information will be kept confidential and will only be accessible to authorized personnel who require it for billing purposes. Our practice follows all HIPAA regulations to ensure that your information is protected.

By signing below, you authorize our practice to keep your credit card information on file and use it for any outstanding balances not covered by your insurance policy.

Thank you for choosing our practice for your healthcare needs. If you have any questions or concerns about this credit card authorization, please do not hesitate to ask our staff.

Patient Name: _____ Date: _____

Credit Card Information:

Credit Card Type: _____ Credit Card Number: _____

Expiration Date: _____	Security Code: _____
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Signature: _____