Physical Therapy & Aquatics Institute

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: _____ SSN: _____

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:

- ☐ Arthritis (rheumatoid /osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema
- ☐ Angina
- ☐ Congestive Heart Failure (or heart disease)
- ☐ Heart Attack (Myocardial infarction)
- ☐ High Blood Pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing Impairment (very hard of hearing, even with hearing aids)
- ☐ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, Bladder, Prostate, or Urination Problems
- ☐ Previous Accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other Disorders
- ☐ Hepatitis / AIDS
- ☐ Prior Surgery
- ☐ Prosthesis / Implants
- ☐ Sleep Dysfunction
- ☐ Injections for Your Current Problem
- ☐ Pacemaker
- ☐ Metal Implants
- ☐ Cancer
- ☐ 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 PHYSICALTHERAPY & 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 YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physical Therapist or Authorized Representative's Signature Date

Empower Physical Therapy & Aquatics Institute

Print or Stamp Name of Physical Therapist, Medical Group or Association

By: _____ _____

Patient's or Patient Representative's Signature Date

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.

Rev. 8/25/2020

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

Effective Date: 8/25/2020

(A) Notifier(s): **EMPOWER PHYSICAL THERAPY & AQUATICS INSTITUTE**

(B) Patient Name: _____ **(C) Identification Number:** _____

HOME HEALTH & HOSPICE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for **(D)** ***SEE BOX D*** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **(D)** ***SEE BOX D*** below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Outpatient Physical Therapy Services	If a patient is under a home health or hospice plan of care under their Medicare Part A or Part B benefits, outpatient physical therapy will not be covered. It is the responsibility of the beneficiary to disclose any home health or hospice treatments being received and provide home health or hospice discharge documentation if home health or hospice services were provided within the past 3 months. If outpatient physical therapy services are denied coverage by Medicare due to home health or hospice services, you will be responsible for the treatments provided and not covered by your Medicare benefits.	97161-97163: … $75-$120 97164: … $45-$61 97112: …. $20-$105 97150: …. $12-$35 97140: …. $15-$50

WHAT YOU NEED TO DO NOW:
- **This ABN has been issued since the provider has reason to believe that the patient has been enrolled, or currently enrolled, in home health or hospice services.**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **(D)** ***SEE BOX D*** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1**. I want the **(D)** ***SEE BOX D*** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). **I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2**. I want the **(D)** ***SEE BOX D*** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3**. **I don't want the (D)** ***SEE BOX D*** listed above. I understand with this choice I am not responsible for payment for the **(D)** ***SEE BOX D*** listed above. Also understand with this choice, **I cannot appeal to see if Medicare would pay.**

(H) Additional Information: Medicare Part B pays for physical therapy as long as it is medically necessary, but only up to the annual benefit cap of $2,040.00. Prior to reaching the benefit cap, you pay 20% of the Medicare-approved amount after you have met your annual deductible of $198.00. After you have reached the $2,040.00 benefit cap, you may be responsible for 100% of the charge, unless your physical therapist can show proof of medical necessity to continue care under Medicare's medical necessity criteria. Please consult with your therapist regarding your plan of care.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: _____ **(J) Date:** _____

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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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.

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HIPAA Contact: Bobby Hamidi (949) 939-8198

Effective Date: 8/25/2020

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?

   ☐ Fever over 100.4° Yes ☐ No ☐
   ☐ Persistent cough Yes ☐ No ☐
   ☐ Shortness of breath Yes ☐ No ☐
   ☐ Fatigue Yes ☐ No ☐
   ☐ Anorexia Yes ☐ No ☐
   ☐ Sputum production Yes ☐ No ☐
   ☐ Myalgia Yes ☐ No ☐

   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?
   ☐ Fever over 100.4° Yes ☐ No ☐
   ☐ Persistent cough Yes ☐ No ☐
   ☐ Shortness of breath Yes ☐ No ☐
   ☐ Fatigue Yes ☐ No ☐
   ☐ Anorexia Yes ☐ No ☐
   ☐ Sputum production Yes ☐ No ☐
   ☐ Myalgia Yes ☐ No ☐

   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: MasterCard Credit Card Number: _____

Expiration Date: _____	Security Code: _____

Signature: _____