Ability

737 Pearl Street, Suite 108
La Jolla, California 92037
Phone: 858.456.2114
Fax: 858.456.2103
www.abilityrehabSD.com

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Name: _____ Age: _____ Sex: _____
Last First Middle

Address: _____
Street City State Zip

Primary Phone: _____ Secondary Phone: _____

Social Security #: _____ Date of Birth: _____ Marital Status: _____

Email Address: _____

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Spouse's Employer: _____ Phone: _____

Referring Doctor: _____ ***Phone:*** _____ ***Specialty:*** _____

Primary Care Doctor: _____ ***Phone:*** _____

How did you find Ability Rehab? _____

Person to notify in case of emergency OUTSIDE of household:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____
Street City State Zip

Medical History

Have you been treated here or by another physical therapist previously? Yes _____ No _____
If yes, where? _____ When? _____
Was it for the same condition? Yes _____ No _____ If not, please specify : _____
_____

HAVE YOU RECENTLY RECEIVED ANY TYPE OF HOME HEALTH? Yes _____ No_____

Name of Home Health Agency: _____

If you have not been formally released from home health OR are currently receiving home health, please be aware that insurance will not cover both services and you will be responsible for all costs.

***INITIAL*:**_____

PRIMARY Insurance Company: _____ Phone #: (____)_____-_____

Policy Holder's Name:_____
Last First Middle

Policy Holder's Social Security #:_____ Date of Birth: _____

Address: _____
Street City State Zip

Policy Holder's Employer: _____

Employer's Address:_____
Street City State Zip

Position: _____ Phone #: (____)_____-_____

Is there Secondary Insurance? Yes _____ No _____

Name of Secondary Insurance Company:_____

****

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of injury:_____

****

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER_____

****

FINANCIAL 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 our billing department. If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Ability Rehabilitation Specialists (ARS). I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, Auto, etc.), then I am financially responsible and agree to pay for all charges related to services provided to the patient at ARS. In the event that services deemed medically necessary by your physical therapist are not covered, not authorized or deemed not medically necessary by my Health Plan, then I the Member will be held financially responsible and agree to pay for all the charges related to the services provided by ARS.

Although I have requested Ability Rehabilitation Specialists to bill my insurance company on my behalf, I clearly understand that I am responsible to ARS for payment on my account regardless of the status of my insurance claim.

I hereby authorize Ability Rehabilitation Specialists to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment.

Patient's Signature: _____ Date:_____

Parent or Authorized Representative (if applicable): _____

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CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____, hereby consent to the therapeutic procedures outlined below, to be performed by Ability Rehabilitation Specialists and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions, &/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, e-stim, and ultrasound; and special procedures such as taping.
- 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 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 Ability Rehabilitation Specialists or from any other source.

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

Patient's Signature: _____ Date:_____

Parent or Authorized Representative (if applicable): _____

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 Signature: _____ Date: _____

Parent or Authorized Representative (if applicable): _____

To ensure you receive the best quality care, staff at Ability Rehabilitation Specialists must speak with other medical professionals and/or personal contacts involved in your care. If there are any other individuals who may be involved in your care that you would like Ability Rehabilitation to be able to communicate with, please list those individuals below:

Examples include family, friends, caregivers, secretaries, transportation company etc.

1) _____
(name and phone number)
2) _____
(name and phone number)
3) _____
(name and phone number)

CONTINUE ON BACK

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PATIENT MISSED APPOINTMENT POLICY

We request that you keep all of your appointments, with the exception of serious emergencies. If you need to re-schedule an appointment we require 24 hours notice. As soon as you are aware of a conflict with your appointment, please call the office immediately and leave a message.

In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **$ 50.00** fee.

In instances of repeated non-compliance with your scheduled visits, we also 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 order.

Your adherence to this policy enables us to continue to offer optimal treatment times for you and all of our clients. Please sign below in acknowledgement of this policy.

Patient's Signature: _____ Date:_____

Parent or Authorized Representative (if applicable): _____

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HEALTH HISTORY

Name: _____ Age: ____ Gender: _____ Date of Exam: _____
Occupation: _____ Date of Injury: _____

1. Do you have any of the following medical Conditions? Please Circle

Yes No Arthritis
Yes No Heart Problems
Yes No Pacemaker
Yes No High Blood Pressure
Yes No History of Stroke
Yes No Glaucoma or Ocular Herpes
Yes No Diabetes
Yes No Numbness or tingling in arms or legs
Yes No Cancer
Yes No Infection, please describe_____
Yes No Recent fractures (broken bones) if so please list _____
Yes No Serious Injury, explain_____
Yes No Allergies to medication, if so please list _____
Yes No Allergies, other _____
Yes No Major surgery, type _____
Yes No Headaches, type_____

1. List any other history or medical conditions or illnesses:

_____

2. What medication(s) are you currently using? _____

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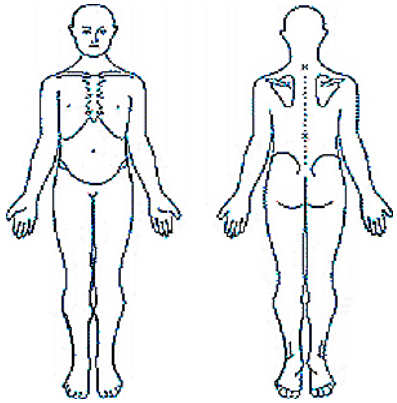
3. Please indicate on the diagram below that location of your pain and describe the type of pain (sharp, dull, aching, shooting, etc.)



Please continue on back……

HEALTH HISTORY (CONTINUED)

Name: _____ Date:_____

4. How did the injury occur? (Please be specific) _____
   _____

5. Did you have surgery for this injury, and describe what type and the date of surgery?
   _____
   _____

6. Please rate your pain below by choosing a number from the Pain Scale which represents your pain at its lowest, average, and highest:
   PAIN SCALE
   0-No Pain
   1-2 Mild
   3-4 Discomforting pain/which may be ignored
   5 Discomforting pain/which may be distracted
   6 Distressing pain, but able to perform tasks
   7-8 Intolerable pain, concentration is difficult/able to perform some tasks
   9-10 Intolerable pain and hospital care is required

6. Is your pain getting better? _____ worse?_____ same?_____

7. Have you already received treatment for this problem at other locations?
   Please circle/the following:
   Medical Doctor Yes No
   Chiropractor Yes No
   Physical Therapist Yes No
   Dentist Yes No
   Psychologist Yes No
   Other _____

8. What test(s) or treatment(s) have you had concerning this problem?
   Please check.
   _____X-ray _____ Myelogram
   _____CT Scan _____ Cortisone Injections
   _____ MRI _____ Biofeedback
   _____ EMG
   _____ Other, please explain/similar problem in the past?

9. Are you currently working? Yes No
   If no, last day worked: _____

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Privacy Officer: Jorge Sarmiento, Vice President
Phone: 858-456-2114
Email: abilityrehab@yahoo.com

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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.

Your Rights: You have the right to…

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices: You have some choices in the way that we use and share information as we…

Tell family and friends about your condition; provide disaster relief; include you in a hospital directory, provide mental health care; market our services and sell your information; raise funds.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell

us to share information with your family, close friends, or others involved in your care; share information in a disaster relief situation; include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information for marketing purposes or sale of your information unless you give us written permission. In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: We may use and share your information as we…

Treat you: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 10/29/2013