



WE ARE EXTENDING CREDIT TO YOUR CLIENT BASED SOLELY ON YOUR GUARANTEE TO PROTECT US.

TO: _____ **RE:** _____

RE: Authorization and agreement to pay physical therapist fees.

I do hereby authorize the BEVERLY HILLS CENTER FOR PHYSICAL THERAPY AND REHABILITATION INC., (“Center”), to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved, (“Accident”).

I hereby authorize and direct you, my attorney, to pay directly to (Center) from my portion of the proceeds of any recovery which may be paid me through my attorney, such sums that may be due and owing for medical services rendered to me by reason of this Accident, as well as for consultations, depositions, and court appearances on my behalf.

I hereby instruct my attorney to immediately furnish (Center) with all information necessary to allow (Center) to immediately bill any applicable insurance policy in effect including but not limited to health insurance, automobile insurance medical payment coverage, etc. I hereby instruct and authorize (Center) to immediately bill said insurance companies for all charges associated with my treatment for this Accident claim. In the event of any recovery from the Accident, I specifically waive any and all contractual limits that may exist between any such insurance company and (Center) for the services rendered to me and acknowledge that (Center) will be entitled to receive payments from any such insurance company as only a partial payment towards my bill. I further instruct my attorney to cooperate with (Center) to provide said information as soon as possible.

I fully understand that I am directly and fully responsible to (Center) for all medical bills submitted, for services rendered and to be rendered to me, and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient’s Signature: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe and to be bound by all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said (Center).

Dated: _____ Attorney’s Signature: _____

To Attorney: Please sign and return one copy to the (Center). Keep one copy for your records. Thank you.

Beverly Hills Center for Physical Therapy
Confidential Medical Questionnaire

Patient Name: _____

- 1) What medications are you presently taking? _____
- 2) Do you have any of the following conditions?
- | | | | |
|----------------|------------------|-----------------|----------------------|
| Heart Disorder | Pacemaker | Diabetes | High Blood Pressure |
| Cancer | Metal Implants | Kidney Disorder | Respiratory Disorder |
| Headaches | Vision Disorder | Alcohol/Drug | Incontinence |
| Arthritis | Hearing Disorder | Depression | Allergies |
- 3) Present condition began when? _____

Please Circle

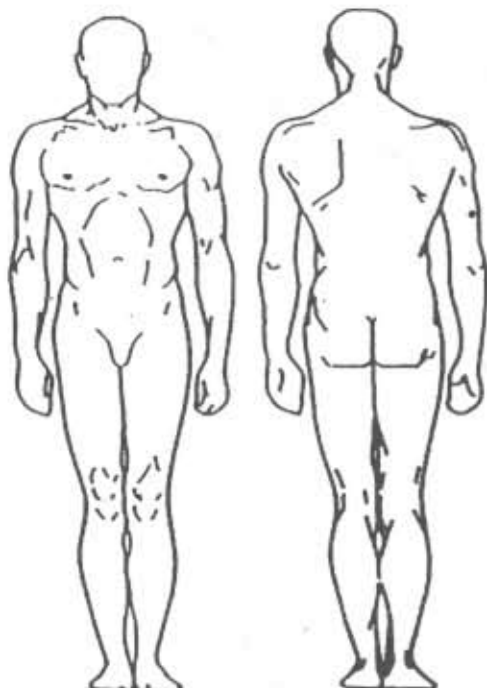
- | | | | | | | | |
|--|-----------|--------------|----------|------------|----------|---------|----------|
| 4) Have you had surgery for this condition? | Yes | No | | | | | |
| 5) Previous treatment for this condition? | Yes | No | | | | | |
| 6) Have you had this condition previously? | Yes | No | | | | | |
| 7) Physical therapy or chiropractic care? | Yes | No | | | | | |
| 8) Symptoms came on? | Gradually | Suddenly | | | | | |
| 9) Are your symptoms? | Constant | Intermittent | | | | | |
| 10) Diagnostic Tests Done? | X-rays | MRI | CT Scan | NVC Test | Other | | |
| 11) Signs and Symptoms? | Dizziness | Weakness | Numbing | Pain | Tingling | Burning | Headache |
| 12) What decreases your symptoms? | _____ | | | | | | |
| 13) What increases your symptoms? | _____ | | | | | | |
| 14) When do you feel better? | _____ | | | | | | |
| 15) When do you feel worse? | _____ | | | | | | |
| 16) Daily activities affected by this condition? | Sitting | Standing | Stairs | Walking | Sleeping | | |
| | Driving | Lifting | Reaching | Employment | | | |
| | Writing | Eating | Washing | Bathing | Sports | | |
| 17) What are your goals for physical therapy? | _____ | | | | | | |

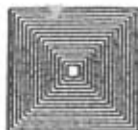
Pain/Discomfort Scale

Circle the number that indicates pain
 (0 = no pain at all;
 10 = need to call 911/emergency pain)

- 1) Today? 1 2 3 4 5 6 7 8 9 10
 2) Worst? 1 2 3 4 5 6 7 8 9 10
 3) Least? 1 2 3 4 5 6 7 8 9 10

Body Chart





Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

TO ALL PATIENTS

DATE: _____

PATIENT NAME: _____

PLEASE BE AWARE THAT BLUE CROSS AND OTHER HEALTH INSURANCE COMPANIES HAVE TIME LIMITS IN WHICH TO BILL THEM.

IF YOU DO NOT GIVE US YOUR MEDICAL INSURANCE INFORMATION WHEN YOU FIRST COME TO US FOR TREATMENT, AND IF AT A LATER DATE YOU DECIDE YOU WANT US TO BILL YOUR INSURANCE, IF THEY DO NOT PAY US, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

x

Signed

AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Patient's Name _____

Insured's Name _____

Social Security No. _____

Policy No. or Claim No. _____

Insurance Company _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. _____

Pay Medical Provider:

**BEVERLY HILLS CENTER FOR
PHYSICAL THERAPY AND
REHABILITATION, INC.
9033 WILSHIRE BLVD., SUITE 409
BEVERLY HILLS, CA 90211**

1. I authorize the **RELEASE OF ANY INFORMATION** concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy or Social Security Act.

2. In consideration of the above-named medical provider's rendering of treatment to me without immediate compensation therefore I authorize and **IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT** of the above named medical provider's bill for treatment rendered to me out of the proceeds of any judgment or settlement in my case and, furthermore, from any insurance company providing coverage to me for such expenses.

3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment, I understand, authorize, and agree that no payments due me under said contract of insurance shall be made to me for any other medical expenses incurred until the above medical provider's **BILL FOR MY TREATMENT IS FIRST PAID IN FULL**.

4. I give assignment and lien in any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

5. In the event any insurance company obligated by contractual agreement to make payment to me or to the physician refuses to make such payment upon demand, I hereby **IRREVOCABLY ASSIGN AND TRANSFER** to the medical provider any **CAUSE OF ACTION** that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in his name and further to compromise, settle, or otherwise resolve said claim.

6. I waive the **STATUTE OF LIMITATIONS** regarding my provider right to recover.

7. I permit a **COPY OF THIS AUTHORIZATION** to be used in place of the original.

8. I, hereby appoint the above named medical provider and any of their duly authorized agents and employees, to endorse any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

You are instructed to **PAY DIRECTLY TO THE** above named medical provider at his office for all professional services rendered to me by his office.

This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim.

Any sum of money paid under this assignment shall be credited to my account.

Patient's signature: _____

Insured's signature: _____
(if different or required)

Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Beverly Hills Center's Notice of Information Practices. I understand that Beverly Hills Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Beverly Hills Center's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

I also authorize Beverly Hills Center to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date

Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.

NOTICE OF PATIENT INFORMATION PRACTICES

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.

BEVERLY HILLS CENTER FOR PHYSICAL THERAPY'S LEGAL DUTY

Beverly Hills Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Beverly Hills Center 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, Beverly Hills Center for 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.

Beverly Hills Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Beverly Hills Center'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 future disclosures at any time.

Beverly Hills Center 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 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 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 emergency circumstances. Beverly Hills Center 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 Beverly Hills Center 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. For further information on Beverly Hills Center's health information practices or if you have a complaint, please contact the following person:

Beverly Hills Center for Physical Therapy and Rehabilitation, Inc.

9033 Wilshire Blvd., Suite 409, Beverly Hills, CA 90211
Practice Address, Practice City, Practice State Practice Zip
Telephone: 310/278-0204 Fax: 310/278-0171



DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date



WE ARE EXTENDING CREDIT TO YOUR CLIENT BASED SOLELY ON YOUR GUARANTEE TO PROTECT US.

TO: _____ **RE:** _____

RE: Authorization and agreement to pay physical therapist fees.

I do hereby authorize the BEVERLY HILLS CENTER FOR PHYSICAL THERAPY AND REHABILITATION INC., (“Center”), to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved, (“Accident”).

I hereby authorize and direct you, my attorney, to pay directly to (Center) from my portion of the proceeds of any recovery which may be paid me through my attorney, such sums that may be due and owing for medical services rendered to me by reason of this Accident, as well as for consultations, depositions, and court appearances on my behalf.

I hereby instruct my attorney to immediately furnish (Center) with all information necessary to allow (Center) to immediately bill any applicable insurance policy in effect including but not limited to health insurance, automobile insurance medical payment coverage, etc. I hereby instruct and authorize (Center) to immediately bill said insurance companies for all charges associated with my treatment for this Accident claim. In the event of any recovery from the Accident, I specifically waive any and all contractual limits that may exist between any such insurance company and (Center) for the services rendered to me and acknowledge that (Center) will be entitled to receive payments from any such insurance company as only a partial payment towards my bill. I further instruct my attorney to cooperate with (Center) to provide said information as soon as possible.

I fully understand that I am directly and fully responsible to (Center) for all medical bills submitted, for services rendered and to be rendered to me, and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient’s Signature: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe and to be bound by all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said (Center).

Dated: _____ Attorney’s Signature: _____

To Attorney: Please sign and return one copy to the (Center). Keep one copy for your records. Thank you.

Beverly Hills Center for Physical Therapy
Confidential Medical Questionnaire

Patient Name: _____

- 1) What medications are you presently taking? _____
- 2) Do you have any of the following conditions?
- | | | | |
|----------------|------------------|-----------------|----------------------|
| Heart Disorder | Pacemaker | Diabetes | High Blood Pressure |
| Cancer | Metal Implants | Kidney Disorder | Respiratory Disorder |
| Headaches | Vision Disorder | Alcohol/Drug | Incontinence |
| Arthritis | Hearing Disorder | Depression | Allergies |
- 3) Present condition began when? _____

Please Circle

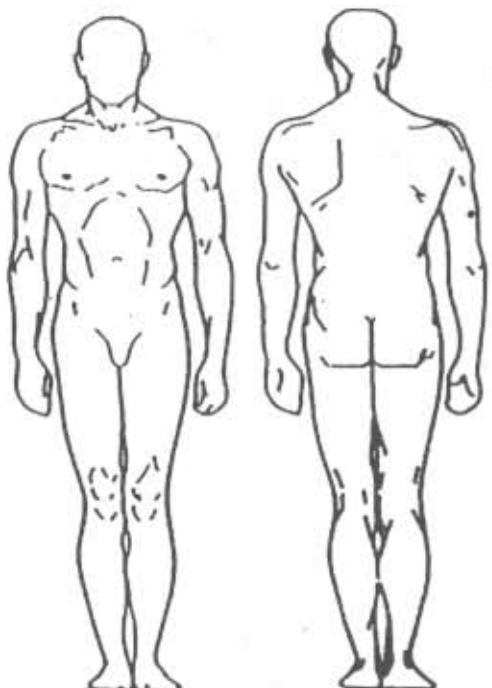
- | | | | | | | | |
|--|-----------|--------------|----------|------------|----------|---------|----------|
| 4) Have you had surgery for this condition? | Yes | No | | | | | |
| 5) Previous treatment for this condition? | Yes | No | | | | | |
| 6) Have you had this condition previously? | Yes | No | | | | | |
| 7) Physical therapy or chiropractic care? | Yes | No | | | | | |
| 8) Symptoms came on? | Gradually | Suddenly | | | | | |
| 9) Are your symptoms? | Constant | Intermittent | | | | | |
| 10) Diagnostic Tests Done? | X-rays | MRI | CT Scan | NVC Test | Other | | |
| 11) Signs and Symptoms? | Dizziness | Weakness | Numbing | Pain | Tingling | Burning | Headache |
| 12) What decreases your symptoms? | _____ | | | | | | |
| 13) What increases your symptoms? | _____ | | | | | | |
| 14) When do you feel better? | _____ | | | | | | |
| 15) When do you feel worse? | _____ | | | | | | |
| 16) Daily activities affected by this condition? | Sitting | Standing | Stairs | Walking | Sleeping | | |
| | Driving | Lifting | Reaching | Employment | | | |
| | Writing | Eating | Washing | Bathing | Sports | | |
| 17) What are your goals for physical therapy? | _____ | | | | | | |

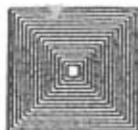
Pain/Discomfort Scale

Circle the number that indicates pain
 (0 = no pain at all;
 10 = need to call 911/emergency pain)

- 1) Today? 1 2 3 4 5 6 7 8 9 10
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Body Chart





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PHYSICAL THERAPY and
REHABILITATION, INC.

TO ALL PATIENTS

DATE: _____

PATIENT NAME: _____

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x

Signed

AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Patient's Name _____

Insured's Name _____

Social Security No. _____

Policy No. or Claim No. _____

Insurance Company _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. _____

Pay Medical Provider:

**BEVERLY HILLS CENTER FOR
PHYSICAL THERAPY AND
REHABILITATION, INC.
9033 WILSHIRE BLVD., SUITE 409
BEVERLY HILLS, CA 90211**

1. I authorize the **RELEASE OF ANY INFORMATION** concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy or Social Security Act.

2. In consideration of the above-named medical provider's rendering of treatment to me without immediate compensation therefore I authorize and **IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT** of the above named medical provider's bill for treatment rendered to me out of the proceeds of any judgment or settlement in my case and, furthermore, from any insurance company providing coverage to me for such expenses.

3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment, I understand, authorize, and agree that no payments due me under said contract of insurance shall be made to me for any other medical expenses incurred until the above medical provider's **BILL FOR MY TREATMENT IS FIRST PAID IN FULL**.

4. I give assignment and lien in any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

5. In the event any insurance company obligated by contractual agreement to make payment to me or to the physician refuses to make such payment upon demand, I hereby **IRREVOCABLY ASSIGN AND TRANSFER** to the medical provider any **CAUSE OF ACTION** that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in his name and further to compromise, settle, or otherwise resolve said claim.

6. I waive the **STATUTE OF LIMITATIONS** regarding my provider right to recover.

7. I permit a **COPY OF THIS AUTHORIZATION** to be used in place of the original.

8. I, hereby appoint the above named medical provider and any of their duly authorized agents and employees, to endorse any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

You are instructed to **PAY DIRECTLY TO THE** above named medical provider at his office for all professional services rendered to me by his office.

This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim.

Any sum of money paid under this assignment shall be credited to my account.

Patient's signature: _____

Insured's signature: _____
(if different or required)

Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.
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Patient Name

Signature

Date

I also authorize Beverly Hills Center to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date

Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.

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Beverly Hills Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Beverly Hills Center'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 future disclosures at any time.

Beverly Hills Center 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 Information Practices at any time.

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Beverly Hills Center for Physical Therapy and Rehabilitation, Inc.

9033 Wilshire Blvd., Suite 409, Beverly Hills, CA 90211
Practice Address, Practice City, Practice State Practice Zip
Telephone: 310/278-0204 Fax: 310/278-0171



DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date