

BEVERLY HILLS CENTER FOR PHYSICAL THERAPY

REFERRED BY: _____

Today's Date: _____

For Office Use Only

PI IN PI/IN WC OTHER

ACCT. No.: _____

PATIENT INFORMATION:

Name: _____ Sex: _____ Birth date: ___/___/___
Last First Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ SS#: _____ - _____ - _____ ID/DL#: _____

EMPLOYER:

Company: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: () _____

REFERRING PHYSICIAN: _____ City: _____ State: _____ Zip: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: () _____ - _____

CONTACT PERSON: (In case of emergency) Relationship: _____

Name: _____ Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Injury: Yes No If Yes, Date of Injury: _____

Other Accident: Yes No If Yes, Date of Injury: _____

Auto Accident: Yes No If Yes, Date of Injury: _____

• Describe the Accident: _____

• If Auto Accident, were you:

Driver Front Passenger Right Rear Left Rear

ATTORNEY INFORMATION:

Name: _____ Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Subscriber's Name: _____

Insurance Co.: _____

Policy No.: _____

Insurance Address: _____

Claim No.: _____

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

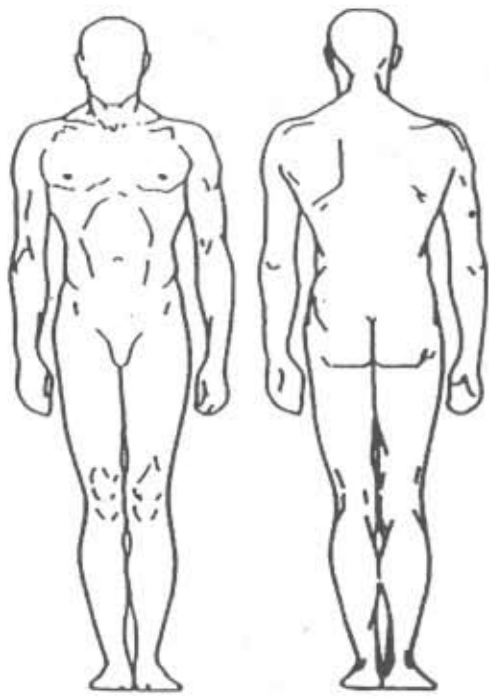
- | | | | | | | | |
|--|-----------|--------------|----------|------------|----------|---------|----------|
| 4) Have you had surgery for this condition? | Yes | No | | | | | |
| 5) Previous treatment for this condition? | Yes | No | | | | | |
| 6) Have you had this condition previously? | Yes | No | | | | | |
| 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 & 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

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.
9730 Wilshire Blvd., Suite 200
Beverly Hills, CA 90212

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.

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.

9730 Wilshire Blvd., Suite 200, Beverly Hills, CA 90212

Telephone: (310) 278-0204

Fax: (310) 278-0171

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

If you are receiving any type of HOME HEALTH CARE - MEDICARE will not pay for your Physical Therapy Treatments at this office, and you will, therefore, be responsible for payment to us.

Because:

HOME HEALTH should provide you with Physical Therapy services.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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

**BEVERLY HILLS CENTER FOR PHYSICAL THERAPY
AND REHABILITATION, INC.
9730 WILSHIRE BLVD., SUITE 200
BEVERLY HILLS, CA 90212**

TO ALL MEDICARE PATIENTS

We will do everything possible to ensure payment is made by Medicare for your treatment. In the event Medicare fails to pay all or a portion of the bill then you will remain responsible for payment.

Thank you.

BHCPT & REHAB, INC.

X

Patient Signature