Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

New Patient Information

Patient's Name:_____ Social Security #: ___ - ___ - ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

Home Telephone:_____ Date of Birth:___/___/___ Age:_____ Sex: ☐ Male ☐ Female

Email:_____ Cell Phone #:_____ Work Phone #: _____

Would you like to receive our newsletters and other related physical therapy information? ☐ Yes ☐ No

Employer:_____ Occupation: _____

Employer's Address:_____ City:_____ State:_____ Zip: _____

Emergency Contact Outside the Home:_____ Phone #: _____

Referring Physician:_____ Primary Care Physician: _____

Onset Date (injury, accident, surgery date or recent date symptoms started): _____

MEDICARE PATIENTS: are you currently enrolled in Home Health? Check one: ☐ Yes ☐ No

If YES: (List Company Name) _____

WORKERS COMPENSATION / AUTO ACCIDENT:

If you want us to bill for Workers Comp or an auto accident, we will do so. We ask that you present us with your private health insurance information as backup. I do not wish to provide a copy of my private health insurance card. I realize that if my workers comp or auto benefits should be denied or exhausted that I would be responsible for any charges incurred.

Please Sign:_____ Date:

CONSENT TO THERAPY

1. I have presented myself to this facility for therapy treatments and consent to diagnostic procedures and care provided by my attending therapist.

2. I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I understand that if I do not attend therapy for two weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with California State Law.

4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and FULLY UNDERSTAND the PATIENT FINANCIAL RESPONSIBLITIES FORM.

5. WORKERS COMPENSATION - I hereby authorize my rehab consultant to receive my records related to my work injury.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature of Patient (or Parent/Guardian if Patient is a Minor – under 18) Date:

Witness (Authorized Signature of Beverly Hills Center for Physical Therapy and Rehabilitation, Inc. Employee) Date:

continue to page 3...

Beverly Hills Center for PHYSICAL THERAPY and REHABILITATION, INC.

New Patient Information

Primary Insurance

Name: _____

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

Insured Name: _____

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

Patient relationship to insured: ☐ Child ☐ Spouse ☐ Self

Group #: _____ ID #: _____

Secondary Insurance

Name: _____

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

Insured Name: _____

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

Patient relationship to insured: ☐ Child ☐ Spouse ☐ Self

Group #: _____ ID #: _____

Workers Compensation:

Insurance Name: _____

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

Adjuster: _____ Phone #: _____ Claim #: _____

Beverly Hills Center for PHYSICAL THERAPY and REHABILITATION, INC.

Medical Screening Questionnaire

Patient's Name:_____ Social Security #: ___ - ___ - ____

Age:_____ Gender: ☐ Male ☐ Female Smoker: ☐ Yes ☐ No Pregnant: ☐ Yes ☐ No

Occupation: _____

Past Medical History:

Please check each condition that you have been told you have (or had):

- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Angina/Chest Pain
- ☐ Ulcers
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Sexually Transmitted Disease
- ☐ Allergies/Asthma
- ☐ Lung Disease

Have you had any recent illness ☐ Yes ☐ No

(Explain if Yes): _____

Do you take blood thinner? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Other: _____

Currently I am experiencing...

Please check all that apply:

- ☐ Fever/chills/sweats
- ☐ Poor balance (falls)
- ☐ Unexplained weight loss
- ☐ Numbness or tingling
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Depression
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Increased pain at night
- ☐ Changes in bowel or bladder function

Past Surgical History: (Please list all & dates):

_____

_____

_____

Please list all current medications:

_____

_____

Have you had an x-ray, MRI, or other imaging study? ☐ Yes ☐ No

Current Symptoms

Where are you currently having symptoms? _____

_____

What date (approximately) did your present pain start? _____

☐ Getting better ☐ About the same ☐ Getting worse

Have you received any treatment for this problem? ☐ Yes ☐ No

Have you ever had this problem before ☐ Yes ☐ No

If so, how was the problem treated? _____

_____

How long did it take for you to feel better? _____

How are you able to sleep at night?

☐ Fine ☐ Moderate Difficulty ☐ Only with medication

What is your personal goal for therapy? _____

_____

Do you have any barriers to learning? if so list: _____

_____

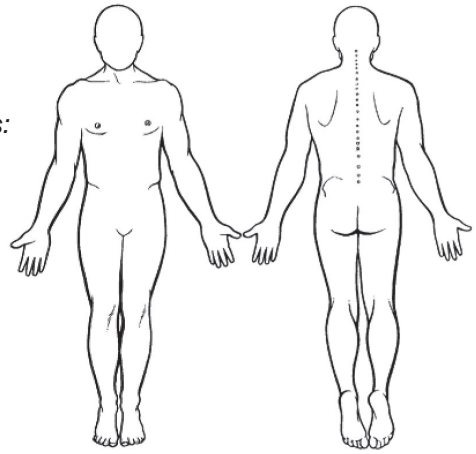
continue to page 2...

Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

Medical Screening Questionnaire

Body Chart:
Please mark the areas where you feel pain on the chart to the right.
Please use the following keys to indicate different types of symptoms:

Pain and Needles = 0000
Stabbing = ////
Burning = XXXX
Deep Ache = ZZZZ



On the scale below, please circle the number which best represents the severity of your pain:

AVERAGE for the last 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

BEST for the last 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

WORST for the last 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle the number below which best represents your overall average level of function:

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better? _____

Please check the activities which make your pain worse:
☐ *sitting* ☐ *lying down* ☐ *standing* ☐ *walking* ☐ *stress*

Any other activities that make your pain worse? _____

Please list the best and worse time of day for your symptoms *Best:* _____ *Worse:* _____

Aggravation Factors: *Identify up to 3 important activities that you are unable to do or are having* difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

THERAPIST USE ONLY

Rating: _____

Rating: _____

Rating: _____

THERAPIST USE ONLY
Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before your (injury or problem)

Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

Medicare Financial Limitation Notification Form

MEDICARE FINANCIAL LIMITATION NOTIFICATION FORM

Effective January 1, 2010 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling $1,860.00 for Medicare Part B outpatient services for Physical, Occupation and Speech therapy services.
The purpose of this notice is to help you make an informed choice about whether or not you wish to continue to receive outpatient physical, occupational or speech therapy after the Medicare Financial limitation has been met, knowing you will be financially responsible for these services.

CMS's financial limitation (Cap) will be applied in the following manner for your outpatient rehabilitation services:

- *Physical and Speech Therapy will share on $XXXXXX. financial limitation (Cap) for both therapies combined.*
- *Occupational Therapy services will have separate $XXXXXX financial limitation.*
- *These financial limitations will be effective until December 31, 2010 unless otherwise changed or suspended by CMS.*

Medicare will subtract your co-insurance from the $ XXXXXX cap and pay $_____ or 80%. The 20% co-insurance, or $_____ will be paid by you or a supplemental insurance you may have. These limits are based off the Medicare fee schedule allowed amount after your $_____ deductible has been met. The cap will be based on services paid by Medicare at the allowable rate, not the provider's charges.

As Medicare providers, we are obligated to inform you of this financial limitation and Medicare's determination that once the $_____ financial limitation for Physical, Occupational and/or Speech therapy benefit is met as described above, you will be financially responsible for any services provided, unless you qualify for a Cap exception as outlined below. As a courtesy, we will track the services you receive from us and notify you when the amount is close to meeting Medicare's $1,800.00 financial limit. This will allow you to make an informed consumer decision regarding whether or not you want to continue therapy services and accept financial responsibility for the cost of any appropriate medically necessary continued care provided. Medically necessary therapy services you receive beyond the cap may be continued at a Hospital Outpatient Rehabilitation department and billed to Medicare, as this type of facility is exempt from the financial limitation imposed by Medicare.

The $1,860.00 financial limitation is your annual Medicare insurance benefit, regardless of which non-hospital based therapy providers deliver the service. If you received physical, occupational or speech therapy prior to attending therapy at our center, please be aware that those services will be included in your financial limitation total. ***Please assist us in ensuring you stay within the cap limits by informing our Scheduling Coordinator of any physical, occupational or speech therapy services you have received between January 1, 2010 and today****. We will be sure to include any self-reported amount in your beginning balance and notify you when you have reached the cap at our facility so you may make an informed decision about continuing care that is medically necessary beyond the financial limitation.*

Medicare Therapy Cap Exceptions

Congress has made provisions for exceptions to the Medicare Cap for which you may qualify when therapy services beyond the financial limitation (cap) are medically necessary. Your therapist will discuss your status with you as you near the cap. If you have already exceeded your financial limit (cap) for the 2010 calendar year, your therapist will discuss your ability to qualify for further treatment under and exception after your evaluation or re-evaluation. If you do qualify for an exception, you will be financially responsible for continued care beyond the limitation. Ask our staff what the estimated cost of items and services will be in the event that you do not qualify for an exception.

Patient Signature *Date:*

This notice was adapted from CMS's "Notice of Exclusion from Medicare Benefits" form and is not an all-inclusive list of excluded Medicare benefits. This notice pertains to Medicare's financial limitation and excluded benefits beyond $1,860.00.

Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

Patient Responsibilities

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Beverly Hills Center for Physical Therapy and Rehabilitation, Inc. and Rehabilitation, Inc. We consider it a privilege that you've chosen to see a Beverly Hills Center for physical therapist. From the moment you walk in the door until the time we regrettably have to say our goodbyes, we are committed to providing you with amazing service throughout your experience with us.

INSURANCE

We need accurate information about your insurance. Therefore, please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID, or government issued ID. Please report any changes to your insurance coverage, demographics, etc. to your clinic's Patient Service Specialist (PSS).

The PSS will verify your benefits and eligibility with your insurance company. All benefits are subject to medical necessity and do not represent a guarantee of payment by your insurance company but is a summary of information.

CO-PAYS

We are required by our insurance contracts to collect all co-pay amounts at the time of service. We accept cash, check, Visa, and MasterCard, American Express, and Discover.

COINSURANCE

Coinsurance is an estimated percentage of an eligible expense that you are required to pay for a covered service. Coinsurances can be paid at time of service.

DEDUCTIBLES

If you have not met your deductible, we will estimate the expected insurance payment for your visit and request that amount. This is an estimate only and you may receive a statement with additional balances after your visit.

Name (Print) Sign Date

Beverly Hills Center for PHYSICAL THERAPY and REHABILITATION, INC.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Beverly Hills Center for Physical Therapy and Rehabilitation, Inc. and each of its subsidiaries, affiliates, and entities managed or controlled by Beverly Hills Center for Physical Therapy and Rehabilitation, Inc. including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Beverly Hills Center for Physical Therapy and Rehabilitation, Inc.. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Compliance Officer, Beverly Hills Center for Physical Therapy and Rehabilitation, Inc.,

USES OR DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or healthcare operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: *With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors, physical therapists, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.*

Uses and Disclosures for Payment: *With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.*

Uses and Disclosures for Health Care Operations: *With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care provided in our facilities.*

Individuals Involved In Your Care: *With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.*

Business Associates: *Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times, it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.*

Appointments and Services: *We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Compliance Officer, Beverly Hills Center for Physical Therapy and Rehabilitation, Inc., 9730 Wilshire Blvd #200 Beverly Hills, CA 90212.*

Research: *In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy*

will be protected by strict confidentiality requirements applied

by an Institutional review board that oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures: *We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:*

- *any purpose required by law.*
- *public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.*
- *if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.*
- *to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.*
- *to your employer when we have provided health care to you at the request of your employer; to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;*
- *court or administrative ordered subpoena or discovery request;*
- *to law enforcement officials as required by law to report wounds and injuries and crimes;*
- *to coroners and/or funeral directors consistent with law;*
- *if necessary to arrange an organ or tissue donation from you or a transplant for you;*
- *if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and*
- *to workers' compensation agencies for workers' compensation benefit determination.*

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Access to Your Personal Health Information: *You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.*

Amendments to Your Personal Health Information: *You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/ correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records. .* ***Information:*** *You have the right to receive an accounting of certain disclosures made by us of your personal health information after September 01, 2004. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.*

Accounting for Disclosures of Your Personal Health

Restrictions on Use and Disclosure of Your Personal Health Information: *You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed- to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.*

Workers' Compensation: *For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose*
your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

Complaints: *If you believe your privacy rights have been violated, you can file a complaint in writing with the Compliance Officer, Beverly Hills Center for Physical Therapy and Rehabilitation, Inc., 9730 Wilshire Blvd #200 Beverly Hills, CA 90212. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.*

For Further Information: *If you have questions or need further assistance regarding this Notice, you may contact the Compliance Officer, Beverly Hills Center for Physical Therapy and Rehabilitation, Inc., 9730 Wilshire Blvd #200 Beverly Hills, CA 90212.*

INFORMATION RELEASE FOR INDIVIDUALS INVOLVED IN PATIENT'S CARE:

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 such as my attorney, doctors, etc. must be verified before the release of any information.

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____

I do NOT wish to have my health information disclosed to the individuals below, even though they are involved in my care:

Name: _____ *Relationship:* _____

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ *Power of Attorney* ☐ *Guardian* ☐ *Surrogate Decision-maker* ☐ *Executor of Legal Rep.* ☐ *Parent*

☐ *Other (please specify):* _____

_____

Name (Print) *Sign* *Date*