PHYSICAL THERAPY INC

500 E. Olive Avenue Suite 325 Burbank, CA 91501
(818) 955-5786

PATIENT'S PERSONAL INFORMATION

GENERAL

Last Name: _____ First: _____ M.I.:_____

Address: _____ Apt.: _____ City: _____
Number Street

State: _____ Zip: _____ Home Telephone: (_____)_____ Cell Phone: (_____)_____

Date of Birth: _____/_____/_____ Gender: M____ F____ Dominant Hand: L____ R____
MM DD YYYY

Social Security Number: _____-_____-_____ Driver's License Number: _____

Email Address: _____

Emergency contact/Relation:_____ Phone (_____)_____

EMPLOYMENT

Employer: _____ Occupation:_____
Specific Job Title

Employer Address: _____ City: _____
Number Street

State: _____ Zip: _____ Telephone: (_____)_____

INSURANCE

Insurance Company Name: _____ Group Number: _____ Policy Number_____

Address: _____ City: _____ State: _____ Zip: _____
Number Street

Insured's Date of Birth: _____/_____/_____ Insured's Name: _____
MM DD YYYY

Insured's Social Security Number: _____-_____-_____ Relationship to Insured: _____

ATTORNEY

Attorney: _____ Phone Number: (_____)_____

Workman's Comp - Adjuster: _____ Claim #_____

AUTHORIZATION

By signing this document I confirm that all information provided on this form is true and accurate to my knowledge.

X_____ _____
Signature Date

HEALTH CONDITION INFORMATION

Name: _____ DOB: _____/_____/_____

Chief Complaints:_____

Date of Onset/Injury: _____ Date of Surgery:_____

Referred By: _____

List of other health conditions: _____

_____

Surgeries: _____

Pacemaker: Yes_____ No_____

(Females only) Pregnant: Yes_____ No_____

Medication List: _____

1. Briefly describe your symptoms: _____

_____

2. How did your symptoms start? _____

3. Average pain intensity: (please circle one)

Last 24 hours: no pain 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ worst pain

Past week: no pain 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ worst pain

4. How often do you experience your symptoms?

[1] ___ Constantly (76%-100% of the time) [2] ___ Frequently (51%-75% of the time)

[3] ___ Occasionally (26% - 50% of the time) [4] ___ Intermittently (0%-25% of the time

5. How much have your symptoms interfered with your usual daily activities?
(including both work outside the home and housework)

[1] ___ Not at all [2] ___ A little bit [3] ___Moderately [4]___ Quite a bit [5] ___Extremely

7. In general, would you say your overall health right now is...

[1] ___Excellent [2] ___Very good [3] ___Good [4] ___Fair [5] ___Poor

Indicate where you have pain or other symptoms:
xxxx = pain ///// = Numbness/tingling

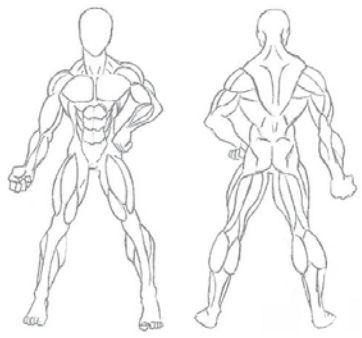
Or you can explain in provided note box:

_____

_____

_____

_____



OFFICE USE ONLY

BP:_____ Pulse:_____ Weight:_____

NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996 (HIPAA)

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.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at BSP Physical Therapy Inc., and we need this record to provide you with quality care and to comply with certain legal requirements.
This notice will tell you about the ways we may use and share medical information about you.
We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Notify you if there has been an intentional breach of security involving your medical information.
4. Follow the terms of the notice that is now in effect.

We Have The Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make any important changes to our privacy practices, we will change this notice and make the new notice available upon request.

3. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. If you desire a copy of any X-ray, the charge is $6 per page. If you desire a copy of your records, BSP will provide you with them for a fee of $25.00. You must make your request in writing.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
5. Request that we change or amend your medical information. This request must be written. We may or may not make the changes you request. We will include your request in your file. If we agree to amend or change your information, we will not remove or alter earlier documents, but will add new information to your file.
6. Transfer copies of your health information to another practice. We will mail the files for you.
7. If our privacy and security measures or systems are breached in any way, we will notify you.
8. Receive a copy of this notice.

4. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. We have a written contract with each business associate, such as a billing service, that requires them to protect your privacy.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: We may use and disclose medical information for the following purposes:

- To contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- As we will need to contact you from time to time, we will use whichever phone number or address you prefer.
- We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us at the address or phone number provided on this form. You may also submit a written complaint to the U.S. Department of Health and Human Services located at:
200 Independence Ave., S.W. Room 509F, Washington, D.C. 20201.
You will not be retaliated against for filing a complaint. If you choose to file a complaint, or for more information or assistance regarding your health information privacy, please contact our office and ask for the Privacy Officer.

6. ACKNOWLEDGMENT

I have received a copy of the BSP Physical Therapy, Inc. Notice of Privacy Practices.

_____ _____ _____

Signature ***Printed Name*** ***Date***

_____

Patient's name, if signing as a parent or guardian

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and may be charged a fee $25.00 to cover the cost of copying and mailing.

Amendments

You have the right to request an amendment be made to you PHI, if you disagree with what is said about you.
This request must be made in writing. If we disagree with you, we are not required to make the change.
You do have the right to submit a written statement about why you disagree that will become part of your record.
We may not amend parts of your medical record that we did not create.

Accounting of Disclosure

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaints should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain, directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of our PHI. These rules require us to provide you with documents, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in future, you will receive a revised notice when you seek treatment from us.

Privacy Contact

If you would like more information about or privacy practices or to file a complaint you may contact:

Jennifer Sanchez, Administrative Assistant
500 E. Olive Ave. Suite 325
Burbank, CA 91501
(818) 955-5786

This Notice will take effect on April 14, 2003 and on.

Patient Signature:_____

Patients Name:_____ Date:_____

CANCELLATION AND NO SHOW POLICY

We require 24-hour notice in the event of a cancellation. It is the patient's responsibility when you call in to have an alternative time in mind that will ensure you get the full prescribed number of treatments that week whenever possible.

Information about cancels: When you cancel or you are a no show, three people are hurt:

***Themselves** because they don't get the treatment they need as prescribed by the doctor and/or staff.

***The Therapist** who now has a hole in their schedule since the time was reserved for that patient Personally.

***Another patient** that could have been scheduled for the treatment if there had been proper notice.

If you CANCEL without proper notice or NO SHOW a $35.00 fee will apply.
This fee applies to all BSP Physical Therapy patients.

I am aware there is a 24-hour cancellation policy. If I cancel without notice or No Show a $35.00 fee will apply.

Patient Signature _____ Date_____

Thank you

Bryn S. Pacheco, PT, DPT, MCMT / BSP Physical Therapy

BSP

PHYSICAL THERAPY INC

Dear Patient(s),

This letter is to inform you that we are going GREEN! We are taking the initiative to reduce paper usage through the use of E-statements. Enroll for E-statements and use your inbox instead of your mailbox. It is convenient which means you get an email notification when your statement is ready to view at anytime and anywhere with internet access. It is secure, no more personal information sitting in your mail box or getting lost. To join E-statements simply provide us your email address and sign to authorize the stoppage of paper statements.

Thank you,

I, _____ authorize BSP Physical Therapy Inc.
to sign me up for E-statements

_____, this will be the last paper statement I will receive.
(Email)

BSP
PHYSICAL THERAPY INC

RULES & REGULATIONS

Please take a moment to read the important rules and regulations below. If you have any questions, please ask one of our team members for assistance.

- Provide, to the best of your ability, your therapist(s) with accurate, complete details about past and present illnesses, hospitalizations, surgical procedures, and medications.
- Inform your therapist(s) whenever you experience a change in your condition or a problem with your treatment.
- Let your therapist(s) know if you do not understand your treatment or what you are expected to do.
- Follow the advice and instructions of your therapist(s) concerning your care.
- Deductibles, co-pays, co-insurance and outstanding balances will be due at the time of service or inform the billing department if you cannot pay your bills. If someone else is paying your bills for you, you must inform the practice who that individual is and how he or she can be contacted.
- Be courteous to the therapist(s), practice staff and other patients, minimize noise and keep the number of visitors to reasonable levels in the waiting area.
- Aggressive behavior toward staff, other patients, or property cannot be condoned, and appropriate action to stop or curtail such behavior will be taken, including discharge from the program and/or pursuit of criminal charges.
- Keep small children in waiting area for safety reasons.
- We reserve the right to refuse service.
- Although we do our best to stay on schedule, please understand there are factors that may cause our team to be off schedule. Therefore, we cannot always guarantee treatment at your appointment time.
- Do not smoke anywhere inside the building.
- Discuss and plan for your post-discharge needs with your therapist.

By signing below, patient certifies that he or she has read, understood and agrees to comply with all of the terms, conditions, Rules and Regulations listed above.

Patient's Name (Please Print) : _____

Patient's Signature _____ Date: _____