ABA Physical Therapy ASSOCIATES

Name: _____

Street Address:_____

_____ AGE:____ Birthdate _____ □M □F
City State Zip (mm/dd/yyyy) (check one)

Home Phone: ( )_____Work Phone ( )_____Cell Phone: ( )_____

May we contact you by Email?_____Employer:_____

Emergency Contact:_____ Phone # ( )_____Relationship:_____

Family Physician:_____ Referred by:_____

INSURANCE INFORMATION

Name of the Insured:_____Insured birthdate:_____

Primary Insurance: _____Group #:_____ ID#_____

Do you have secondary insurance? □No □Yes **Auto Injury?** □No □Yes Date of accident:_____State_____

REMINDERS

I prefer to receive appointment reminders by: □ Home Phone □ Work Phone □ Cell Phone □ Email

□Email _____ Cell Phone Carrier: □ATT □Verizon □Sprint
(Please enter email if not indicated above) Other _____

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INSURANCE INFORMATION RELEASE

I hereby authorize ABA Physical Therapy Associates to release to my insurance company/attorney, any information regarding this illness and/or injury which is required to process my claim.

***Signed*_____*Date*_____**

FINANCIAL RESPONSIBILITY

*I understand that it is **my responsibility** to know and understand my insurance benefits. I hereby assign my insurance benefits to ABA Physical Therapy Associates and agree to be financially responsible for any services that my insurance company will not pay for.*

***Signed*_____**

LATE POLICY:

*In order to respect our patient's time, we make every attempt to start and end our sessions promptly as scheduled. If **you** are late, you are responsible for the full fee for the session.*

***Signed*_____**

CANCELLATION OR NO SHOW POLICY:

*I understand that if I am unable to cancel my scheduled appointment 24 hours in advance, or "No Show," I will be charged a **$50.00 Cancellation/No Show Fee for a half hour appointment** or a **$75.00 cancellation/no show fee for an hour appointment.***

***Signed*_____**

What is Physical Therapy?

Physical therapy is a patient care medical service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and various interventions.

Physical therapy treatment may include any one or a combination of manual treatments, modalities (modalities that use the physical and chemical properties of light, heat and electricity) and therapeutic exercises with or without equipment as deemed appropriate by the physical therapist.

Potential Benefits:

The primary goals and benefits of physical therapy are to restore and maintain normal function and movement. Common benefits associated with physical therapy include, but are not limited to, improvement in joint range of motion, muscle strength and flexibility, cardiovascular endurance, physical performance, body mechanics, decreased pain levels, reduction of future injury risk and prevention of various diseases.

You should gain a greater knowledge about managing your condition and the resources available to you. Your therapist will share their opinion regarding potential results of physical therapy and discuss your treatment options.

Potential Risks:

As with any medical procedure, there are risks. Response to physical therapy treatment varies from person to person. It is not possible to accurately predict your response to a specific treatment, modality, procedure or treatment.

ABA Physical Therapy Associates cannot promise or guarantee that the treatment will resolve or improve your condition.

You have the right to decline any part of your treatment at any time, should you have any concerns.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also ask questions at any time and may discuss with your therapist what the potential risks and benefits of a specific treatment might be.

There is the possibility that physical therapy treatment may result in aggravation of existing symptoms and an increase in your current level of pain or discomfort. This discomfort is usually temporary and should not exceed 24-48 hours. If discomfort does persist, you should contact your physical therapist.

By signing below, I acknowledge that I have read and understood this consent form and agree to proceed with physical therapy evaluation and treatment. I understand that this consent will cover the entire course of treatment for my present condition and for any future condition for which I shall seek treatment from ABA Physical Therapy Associates.

Patient's Name _____ Patient Signature _____ date _____

(If patient is a minor, parent or legal guardian must sign this consent)

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.

ABA Physical Therapy Associates' LEGAL DUTY

ABA Physical Therapy Associates 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

ABA Physical Therapy Associates 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, **ABA Physical Therapy Associates** 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.

ABA Physical Therapy Associates may also use or disclose your personal health information without prior authorization for emergencies. We also provide information when required by law.

In any other situation, **ABA Physical Therapy Associates**' 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.

ABA Physical Therapy Associates 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. **ABA Physical Therapy Associates** 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 **ABA Physical Therapy Associates** 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 **ABA Physical Therapy Associates**' health information practices or if you have a complaint, please contact the following person:

ABA Physical Therapy Associates
Marilyn S. Beames
Office Manager
1670 S. Amphlett Blvd. # 123, San Mateo, CA 94402
Telephone: 650.558.0247 Fax: 650.558.1735
email: info@abaphysicaltherapy.com www.abaphysicaltherapy.com

HIPAA PRIVACY NOTICE AND PATIENT INFORMATION CONSENT FORM

I have read and fully understand ***ABA Physical Therapy Associates***' Notice of Information Practices. I understand that ***ABA Physical Therapy Associates*** 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 ABA Physical Therapy Associates 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 ***ABA Physical Therapy Associates***' 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 _____

Signed_____ Date _____

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Please sign the authorization below if you would like to share your medical information with a family member, friend or medical provider other than the referring physician.

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 _____

Patient Name _____

Signed_____ Date _____

The Activities-Specific Balance Confidence (ABC) Scale

Name: **Date:**

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale from 0% to 100%. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you have any questions about answering any of these items, please ask your therapist.

0% 10 20 30 40 50 60 70 80 90 100%
no confidence completely confident

How confident are you that you will not lose your balance or become unsteady when you…

1. walk around the house? _____%
2. walk up or down stairs? _____%
3. bend over and pick up a slipper from the front of a closet floor? _____%
4. reach for a small can off a shelf at eye level? _____%
5. stand on your tip toes and reach for something above your head? _____%
6. stand on a chair and reach for something? _____%
7. sweep the floor? _____%
8. walk outside of the house to a car parked in the driveway? _____%
9. get into or out of a car? _____%
10. walk across a parking lot to the mall? _____%
11. walk up or down a ramp? _____%
12. walk in a crowded mall where people rapidly walk past you? _____%
13. are bumped into by people as you walk through the mall? _____%
14. step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
15. walk outside on icy sidewalks? _____%

Powell, LE & Myers AM. Journal of Gerontology Med Sci 1995;50(1):M28-34

Balance and Dizziness Questionnaire

Please fill out the entire questionnaire to the best of your ability. We realize the form is long, but because balance problems and dizziness can be related to so many different diagnoses, we need to gain as much information as possible during your initial visit, so that we may spend as much time as possible helping you with your problem.

Patient Name:_____ Date:_____

Date of Birth:_____ Gender:___

Medical History: Have you ever been diagnosed with any of the following conditions? Check all that apply: X

_____ Heart disease	_____ Osteoporosis	_____ Back pain
_____ Stroke	_____ High Blood Pressure	_____ Neck pain
_____ Diabetes	_____ Low Blood Pressure	_____ Epilepsy
_____ Chemical dependency	_____ Arthritis	_____ Depression
_____ Leg injuries	_____ Vision problems	_____ Ear problems
_____ Multiple Sclerosis	_____ Migraine	_____ Anxiety
_____ Polio/Post polio syndrome		_____ Cancer
_____ Neuropathy (sensation problem)		_____ Head Trauma
_____ Parkinson's disease		_____ Meniere's disease

_____ Total Joint Replacement: (circle): knee hip shoulder ankle

_____ Other condition_____

Do you currently experience any of these symptoms in your legs or feet?

_____pain _____ numbness _____tingling _____ swelling

Do you use eyeglasses or contact lenses? YES or NO

Do you use a cane or walker? YES or NO

Do you wear hearing aids? YES or NO

Do you or did you use alcohol? YES or NO How much?_____

How many cups of caffeinated drink per day? (coffee, tea, soda) _____

Have you ever had drug therapy for cancer or intravenous antibiotics? Y or N

Have you fallen in the past year? YES or NO How many times? _____
Please describe the reason for the falls: e.g. tripped on rug in dark room

Did you have an injury from falling which required medical care? If so, please describe:

List all medications you are currently taking, including over- the- counter medications:

Name of medication/ dose

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____

How would you describe your dizziness or balance problem? Grade the severity of the symptom by entering a number from 2(marked), 1(moderate), to 0 (none). Enter 0 if you do not have the symptom.

A. Sensation of imbalance: _____ trouble walking
_____ poor balance
_____ falls

B. Sense of movement of one's own body or the environment:
_____ rotation(spinning, tumbling)
_____ linear movement or pulling
_____ tilting

C. Sensations not associated with movement of the environment:
_____ lightheadedness or faintness
_____ floating
_____ swimming
_____ giddiness
_____ rocking
_____ spinning **inside** the head
_____ fear or avoidance of being in public places

D. Associated Symptoms: _____ sweating
_____ nausea
_____ vomiting
_____ queasiness
_____ tinnitus (ringing in the ears)

E. Impaired Vision: _____ double vision
_____ blurred vision
_____ flashes of light
_____ jumping of vision while walking or in car

Please describe in detail the circumstances and date when the problem began and what were your **initial** symptoms and problems. Was there any stress or anxiety around the time of onset?

If you have spells, please describe a typical spell in as much detail as possible and describe the frequency and duration of the spells:

To what extent is your dizziness or imbalance brought on by:

(check one for each answer)	None	Some	Severely
Turning over in bed, bending over	_____	_____	_____
Looking up	_____	_____	_____
Standing up	_____	_____	_____
Rapid head movements	_____	_____	_____
Walking in a dark room	_____	_____	_____
Walking on uneven surfaces	_____	_____	_____
Loud noises	_____	_____	_____
Cough, sneeze, strain, laugh or blowing up balloons	_____	_____	_____
Movement of objects around you	_____	_____	_____
Moving your eyes while your head is still	_____	_____	_____
Wide open spaces	_____	_____	_____
Tunnels, bridges, supermarkets	_____	_____	_____
Elevators or escalators	_____	_____	_____
Menstrual periods	_____	_____	___

Have you had: Evaluation by a neurologist? YES or NO
Evaluation by an eye doctor? YES or NO
Evaluation by an ear doctor ? YES or NO
Caloric test(water or air in ear)? YES or NO
MRI YES or NO (& was dye given by injection?) YES or NO

Current Functional Status (Please circle appropriate answer)

Are you independent in self care activities? YES NO
Are you working? YES NO Occupation_____
Can you drive in the daytime? YES NO Nightime? YES NO
Are you able to:
Watch TV comfortably? YES NO
Read? YES NO
Go Shopping? YES NO
Be in traffic? YES NO
Use a computer? YES NO

Other activities you have difficulty with? _____

FINANCIAL AGREEMENT

Cancellation or No Show Policy:

I understand that if I am unable to cancel my scheduled appointment 24 hours in advance or if I "No Show" for a scheduled appointment**, I will be charged a $50.00 Cancellation/No Show Fee for a 30 minute appointment and a $75.00 Fee for a one hour appointment *regardless of the reason*.**

Late Policy:

If **you** are late, you are responsible for the full fee for the session. In order to respect our patient's time, our sessions end promptly as scheduled.

Your Financial Responsibility:

You are responsible for any unpaid services rendered. This may include **co-payments, supplies purchased** and **Cancellation/No Show charges**.

Signature:_____Date:_____

Credit Card Option:

In order to pay these charges, ABA Physical Therapy Associates can, with your permission, keep your credit card information securely on file at their main office in San Mateo, California and will charge your credit card for the above-named charges as appropriate. A credit card receipt will be mailed to you each time you are charged for a service.

I give permission for ABA Physical Therapy Associates to securely store my credit card information and submit charges for the above-named costs. I understand that I can cancel this permission at any time by notifying Marilyn Beames at 558-0247 X103.

Signature:_____Date:_____

Credit card type (MasterCard or Visa)

Credit Card # _____Expiration (mm/yy) _____ CVV:_____

Please send my receipt to the following email: _____