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 ______________________

****

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)

ABA PHYSICAL THERAPY ASSOCIATES
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, providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills 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. We may also use your contact information to market wellness services at ABA Physical Therapy.

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

1. Right to a Copy of This Notice
You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy.

2. Right of Access to Inspect and Copy
You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an **Access Request Form**. Access Request Forms are available from our receptionist.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

We may be able to provide you with a summary or explanation of the information. Contact our receptionists for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended
You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Office Manager/receptionists.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made
You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures
You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. Right to Request an Alternative Method of Contact
You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Office Manager or receptionist.

7. Right to Notification if a Breach of Your Medical Information Occurs
You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

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 in writing. 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 ________________

****

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 __________________

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: _______________________________________

Name____ Age_____ Date_____________

Occupation__________________________Are you working? YES / NO Hours/week_____________

1. Describe your symptoms ____

____

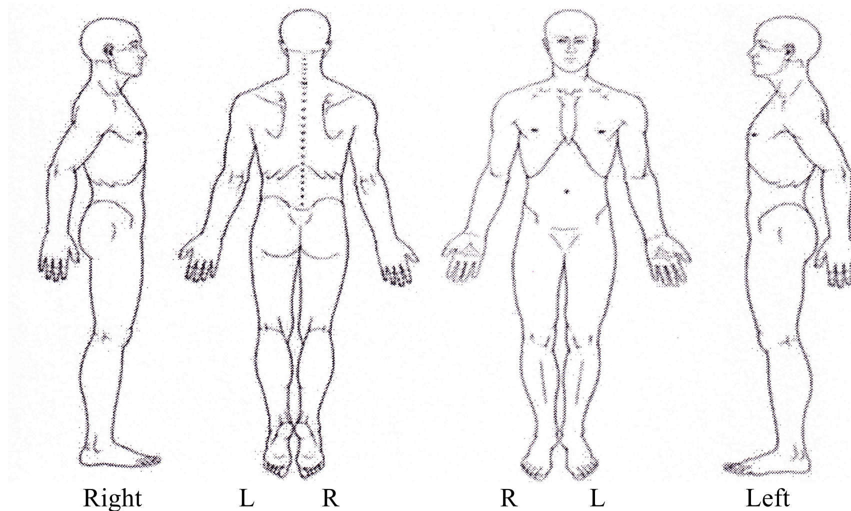
When did your symptoms start? ____

Did your symptoms start: gradually____ suddenly_____ chronic ________ If chronic, how long? _____

Can you remember an incident that caused your symptoms (Please describe)

____

2. **Draw on the figures below where you have pain or other symptoms. Refer to the numbers below the figures to rate your symptoms. If pain varies, please give a range (such as 3-5). If there is more than one area, please rate the pain for each area.**



0	1	2	3	4	5	6	7	8	9	10
None					**Difficult, but can function with medication**					**Unbearable requires hospitalization**

What is most painful area:______________________ Pain at present______ Best______ Worst_____

Next most painful area:_________________________ Pain at present______ Best______ Worst_____

Next most painful area:_________________________ Pain at present______ Best______ Worst_____

3. How often do you experience your symptoms?

a. constantly (76-100% of the day)
b. frequently (51-75% of the day)
c. occasionally (26-50% of the day)
d. intermittently (0-25% of the day)

4. Describe the nature of your symptoms

a. sharp
b. dull ache
c. numb
d. shooting
e. burning
f. tingling

5. How are your symptoms changing?

a. getting better
b. not changing
c. getting worse

6. In general your overall health is…

a. excellent
b. very good
c. good
d. fair
e. poor

7. Who have you seen for your symptoms? a. No one b. medical doctor c. physical therapist d. chiropractor e. Other ________________

What treatment did you receive and when (include surgery)? ________________________________

____

8. Have you had: X-rays date:_____________ CT scan date:_____________ MRI date:______________ Other date:_______________

9. Have you had similar symptoms in the past? YES / NO If you received treatment for similar symptoms who did you see? a. This office b. medical doctor c. chiropractor d. physical therapist e. other

10. How much has pain interfered with your work/housework/daily life?

a. not at all b. a little bit c. moderately d. quite a bit e. extremely

During the past 4 weeks, how much have your symptoms interfered with social activities?

a. not at all b. a little bit c. moderately d. quite a bit e. extremely

Describe physical limitations due to this injury____

____

11. Do your symptoms change during the day? YES / NO How?_________________________________

12. Do your symptoms wake you up at night? YES / NO How often?_____________________________

How many hours do you sleep at night? _____ In what position do you sleep?____________________

13. What aggravates your symptoms?____

____

14. How do you ease your symptoms? (for example, ice, meds, heat, exercise, positions, other) _____

____

15. How long can you sit________ stand________ walk________ before your pain increases?

How long can you sit________ stand________ walk________ before you have to stop?

16. **Please list ANY other PAST medical conditions or accidents (surgeries, illness, trauma) whether or not you feel they are related to your present condition:**

Please list ANY other PRESENT medical conditions:_______________________________________

17. Do you get lightheaded or dizzy when you look up or turn your head? YES / NO

18. Please list all current medications including over-the-counter and herbals:

19. Prior to this injury, did you have a routine exercise program? YES / NO What was it?____________

____

Has this injury changed your exercise? Yes No How?____

20. When did you last have a complete physical from your doctor? ______________________________

Do you experience any of the following symptoms or conditions?

Do you have any metal implants, screws, or pins?	YES_____	NO_____
Have you had a joint replacement?	YES_____	NO_____
Do you have a pacemaker?	YES_____	NO_____
Have you ever had cancer?	YES_____	NO_____
Are you pregnant?	YES_____	NO_____
Do you have heart disease?	YES_____	NO_____
Are you being treated for high blood pressure?	YES_____	NO_____
Do you have diabetes?	YES_____	NO_____
Do you have osteoporosis?	YES_____	NO_____
Do you smoke?	YES_____	NO_____
Do you have increased sweating or night sweats?	YES_____	NO_____
Headaches?	YES_____	NO_____
Weakness?	YES_____	NO_____
Difficulty Swallowing?	YES_____	NO_____
Heartburn/Indigestion?	YES_____	NO_____
Specific food intolerance? Please Specify ______________	YES_____	NO_____
Changes in bowel pattern (texture, color, frequency)?	YES_____	NO_____
Difficulty urinating (starting, stopping)?	YES_____	NO_____
Urine frequency changes?	YES_____	NO_____
Difficulty breathing/shortness of breath?	YES_____	NO_____
Difficulty breathing when lying down?	YES_____	NO_____
Wheezing?	YES_____	NO_____
Do you have swelling in feet or hands?	YES_____	NO_____
Do you have clicking noises in jaw or ear?	YES_____	NO_____
Do you have dizziness/lightheadedness?	YES_____	NO_____
Do you have any problems with balance?	YES_____	NO_____
Do you have a history of falls?	YES_____	NO_____
Do you have pain at night?	YES_____	NO_____

What are your goals for treatment? What would you like to do that you are unable to do now because of this condition?

Patient signature ____Date______________________