PRO PHYSICAL THERAPY NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:_____

Name (First)_____(Last)_____ (M.I.) _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security_____ Birth Date_____ Age _____Sex: M / F

Drivers Lic #_____ Email Address_____

Status Married / Single / Partner /Divored / Widowed **Student** No / Full Time / Part time

Emergency Contact_____ Telephone_____

Referring Physician_____ Telephone _____

Who may we thank for your referral other than your Doctor?_____

Employer_____ **Employment** Full / Part-time / Not Working / Retired

Address_____Phone_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____Injury Date _____

Attorney Involved Yes / No Attorney name _____

Address_____ Telephone # _____

Patient Signature:_____**Date:**_____

(OFFICE USE ONLY) 090904

Primary Insurance_____

Insured Name_____Social Sec#_____D.O.B._____

Secondary Insurance_____

Insured Name_____Social Sec#_____D.O.B._____

Referring Dr. Address _____ UPIN # _____

Area(s) Being Treated:_____

Diagnosis Code _____ Description: _____

Financial Class: CASH BLUECROSS COMMERCIAL MC LIEN W/C

Therapist: Don Brian Steve Heather Gerardo

PRO PHYSICAL THERAPY — MEDICAL HISTORY

Name: Sex: Date of Birth:

Please complete all requested information.

Have you ever had?:	(If Yes, please explain)
High Blood Pressure	☐ No ☐ Yes_____
Heart or Circulation Disorders	☐ No ☐ Yes_____
Seizures	☐ No ☐ Yes_____
Diabetes	☐ No ☐ Yes_____
Cancer	☐ No ☐ Yes_____
Arthritis/Osteoarthritis	☐ No ☐ Yes_____
Osteoporosis	☐ No ☐ Yes_____
Immune Deficiency Disease	☐ No ☐ Yes _____
Other	☐ No ☐ Yes _____

Please list surgeries you have had; please give procedures and dates if possible:

Please list recent diagnostic studies (Cat scan, MRI, Xrays)

Do you have any abnormal trouble with vision? ☐ No ☐ Yes / Hearing? ☐ No ☐ Yes

Have you ever taken steroids or anti-coagulants for an extended period of time? ☐ No ☐ Yes

Have you had an unusual weight gain or loss lately? ☐ No ☐ Yes

(For women only) Are you now pregnant? ☐ No ☐ Yes.

Date of last Menstrual cycle:_____/_____/_____

Do you have any **METAL** anywhere in your body; pins/plate, or **PACEMAKER** ☐ No ☐ Yes Describe what and where:

List any Allergies you have:

List medications you are now taking:

Have you ever had physical therapy treatments before? ☐ No ☐ Yes

If Yes, please indicate where, when, and for what problem:

Describe briefly the history of your present ACCIDENT, INJURY, OR ILLNESS:	Onset date:

_____

_____

_____:

Date of next Doctor appointment_____/_____/_____

Patient Signature	Date:

PRO PHYSICAL THERAPY PAIN SCALE/BODY CHART

Name: **Date:**

This is the Most Important Question in order for us to help you.

- **What Are Your Rehabilitation Goals?**

1.

2.

3.

- What is your perceived level of function for the involved body part as of today? _____%

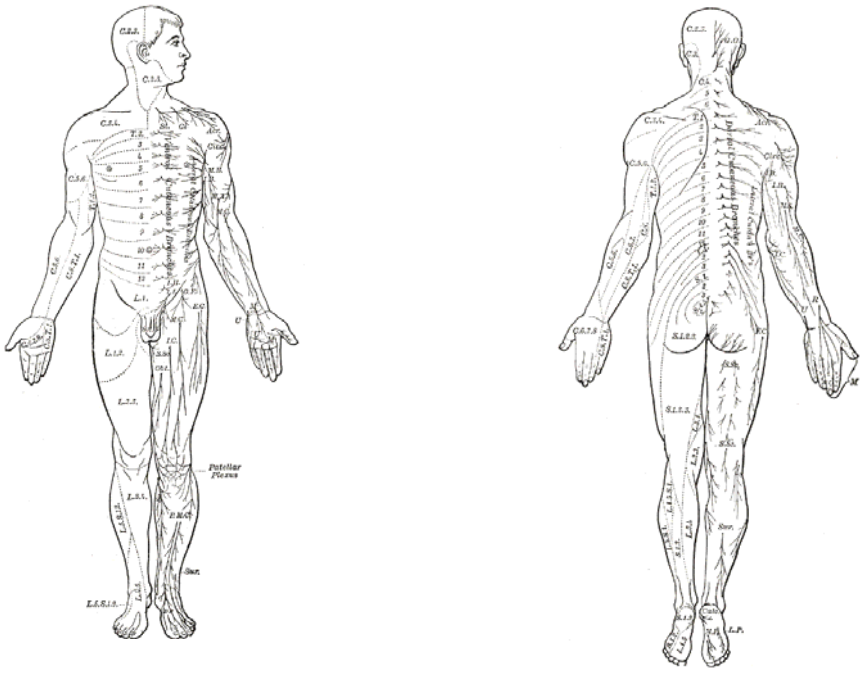
- What is your pain level, please circle a number,

0	1	2	3	4	5	6	7	8	9	10

No Pain Worst Pain

- Please mark your areas of pain on the body to the right

Front* Back*



- Exercise Program:

Briefly, what is your exercise routine? _____

What type of exercise to you *enjoy*? _____

What type of exercise do you *dislike*? _____

What is your commitment level to exercise? _____

* Henry Gray (1825–1861). Anatomy of the Human Body. 1918

Reset Form

NOTICE OF PRIVACY PRACTICE

(Effective April 14, 2003)

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.

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.
For Law Enforcement: We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

PRO PHYSICAL THERAPY

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Name: _____Date of Birth: _____/____/_____

I request and authorize _____to release health care information of the patient named above to:

Name: PRO Physical Therapy _____
Address: 488 S. San Vicente Blvd. _____
City: Los Angeles _____ State: CA _____ Zip Code: 90048 _____

This request and authorization applies to:
☐ Health care information relating to the following treatment, condition, or dates:

_____

☐ All health care information

☐ Other: _____

RELEASE OF HEALTH INFORMATION

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and billing/claims information. This information may be released to:

[ ] Spouse_____

☐ Child(ren)_____

☐ Other_____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages:
Please call ☐ my home ☐ my work ☐ my cell Number to call:_____

If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking me to return your call
☐ ok to text me to my cell number given._____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

488 S. San Vicente Blvd.
Los Angeles, CA 90048
323-655-9055
323-655-9255 fax
www.propt.biz

PRO Physical Therapy

PATIENT EMAIL CONSENT FORM

To address the risks of using email

Patient Name_____

Email_____

Provider: **PRO Physical Therapy**

1. **RISK OF USING EMAIL**

   Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

   a. Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email senders can readily misaddress an email.
   c. Back up copies of email may exist even after the sender or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect email transmitted through their systems.
   e. Email can be intercepted, altered, forwarded, or used without authorization or detection.
   f. Email can be used to introduce viruses into computer systems.
   g. Email can be used as evidence in court
   h. Emails may not be secure, and therefore it is possible that confidentiality of such communications may be breached by a third party.

2. **CONDITIONS FOR USE OF EMAIL**

   Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

   a. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
   b. Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
   c. All email will usually be printed and filed in the patient's medical record.
   d. Office staff may receive and read your messages.
   e. Provider will not forward patient identifiable emails outside PRO Physical Therapy without the patient's prior written consent, except as authorized or required by law.
   f. The patient should not use email for communications regarding sensitive medical information.
   g. Provider is not liable for breach of confidentiality caused by the patient or any third party.
   h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. **INSTRUCTIONS**

   To communicate by email the patient shall:

   a. Avoid the use of his/her employer's computer.
   b. Put the patient's name in the body of the email.
   c. Key in the topic (e.g. medical questions, billing questions) in the subject line.
   d. Inform provider of the changes in his/her email address.
   e. Acknowledge any email received from the provider.
   f. Take precautions to preserve the confidentiality of the email.

PATIENT ACKNOWLEGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risk associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with the patient by email. If I have any questions I may inquire with my treating Physical Therapist, or PRO Physical Therapy.

Patient Signature_____

Date_____

Witness Signature_____

Date_____

Consent for in-clinic care

Unprecedented actions are being taken across the country to reduce the spread of COVID-19, a virus that spreads easily from close contact. The American Physical Therapy Association encourages clinicians to use their professional judgement to determine when, where, and how to provide care, with the understanding that this is not the optimal environment for care.

At PRO Physical Therapy, we are following CDC guidance to minimize exposure in the clinic. All patients must also take responsibility to protect themselves and others by taking the following precautions:

1) Stay home with symptoms of fever, cough, difficulty breathing, or sore throat
2) Wash hands before entering and leaving
3) Use a face covering
4) Practice social distancing, remaining 6 feet away from other patients

Assumption of Risk and Waiver of Liability:

While PRO Physical Therapy has put in place preventative measures to reduce the spread of COVID-19, PRO Physical Therapy cannot guarantee that you will not become infected with COVID-19. Further, engaging in treatment at PRO Physical Therapy could increase your risk of contracting COVID-19, because you will not be at home, and you will be in contact with our staff and possibly other clients of PRO Physical Therapy. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 and that such exposure or infection may result in serious illness or death. I understand that the risk of becoming exposed to or infected by COVID-19 at PRO Physical Therapy. I understand that by not following PRO Physical Therapy preventive measures I may subject others to greater risk for COVID-19.

I hereby release, covenant not to sue, discharge, and hold harmless PRO Physical Therapy, its employees, agents, and representatives (“Released Parties"), of and from any claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to infection with COVID-19.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

By signing below, I acknowledge and represent that I have read the foregoing Assumption of Risk and Waiver of Liability, understand it and sign it voluntarily. I am sufficiently informed about the risks involved to decide whether to sign this Consent, and no oral representations, statements, or inducements, apart from the Consent, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this document for full, adequate, and complete consideration fully intending to be bound by the same. I agree that this Consent shall be governed by and construed in accordance with California law, and that if any of the provisions hereof are found to be unenforceable, the remainder shall be enforced as fully as possible and the unenforceable provision(s) shall be deemed modified to the extent required to permit enforcement of the Assumption of Risk and Wavier of Liability as a whole.

Patient signature:_____ Date:_____

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