

Balance Rehabilitation, Inc.
Physical Therapy – Occupational Therapy – Mental Health and Social Services

Date _____

Patient Information

Patient Name _____
Last First Middle Initial

Home Phone Number _____ Mobile Phone Number _____
(Area Code) Number (Area Code) Number

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

City _____ State _____ Zip Code _____

Age _____ Date of Birth _____ Social Security Number _____

Sex: M F Martial Status: S M D W Drivers License Number _____ State _____

Employer _____ Occupation _____

Business Phone Number _____ E-mail _____
(Area Code) Number

Emergency Contact _____ Phone Number _____
Name Relationship (Area Number) Number

Is this injury the result of a:

Motor Vehicle Accident? Y N If yes, State of Accident _____ Date of Accident _____

Work Related Injury? Y N

Is an attorney Involved? Y N

Assignment of Benefits / Release of Information: I hereby authorize payment directly to Balance Rehabilitation, Inc. for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due. I authorize the release of any medical information necessary to process claims.

Patient Signature (Parent or Guardian if patient is a minor) Relationship Date

Balance Rehabilitation, Inc.

Physical Therapy - Occupational Therapy – Mental Health and Social Services Medical Screening

Date: _____

Name: _____ Age: _____ Sex: M F Weight: _____ Height: _____

Occupation: _____ Hours per week: _____

Physical Activities in Occupation (e.g. sitting, bending, heavy lifting, computer work, etc.): _____

Sports, hobbies, other activities, and frequency/hours involved: _____

Have your or any immediate family member ever been told you have:

	Self	Family
Cancer	yes no	yes no
Diabetes	yes no	yes no
High blood pressure	yes no	yes no
Heart disease	yes no	yes no
Angina/chest pain	yes no	yes no
Stroke	yes no	yes no
Osteoporosis	yes no	yes no
Osteoarthritis	yes no	yes no
Rheumatoid arthritis	yes no	yes no

Have you had or do you experience:

	Self	Family
A change in your health	yes no	yes no
Nausea/vomiting	yes no	yes no
Fever/chills/sweats	yes no	yes no
Unexplained weight change	yes no	yes no
Numbness or tingling	yes no	yes no
Changes in appetite	yes no	yes no
Difficulty swallowing	yes no	yes no
Changes in bowel or bladder function	yes no	yes no
Shortness of breath	yes no	yes no

Are you currently:

Pregnant	yes no
Depressed	yes no
Under Stress	yes no

Are your symptoms (check one):

Getting worse Staying the same Improving

How are you able to sleep at night? (check one):

Fine Moderate Difficulty Only with Medication

Have you had any recent illness that includes upper respiratory infections or urinary tract infections?

Yes No If yes, what? _____

Do you or have you smoked tobacco?

Yes No

If yes _____ Packs X _____ Years

Date of last tobacco use _____

Do you drink alcoholic beverages?

Yes No If yes, drinks _____/week

Date of last physical examination: _____

List any medications you are currently taking:

***If you are experiencing any other unusual symptoms or have any other medical conditions not listed, please inform your physical therapist or list here:**

***No one under the influence of illegal drugs or alcohol may participate in physical therapy at any time.**

I will immediately advise my therapist if there is any change in my physical condition which would alter my response to any questions on this form.

Signature of Patient: _____ Date: _____

BALANCE REHABILITATION, INC.

Financial and Practice Policies

PLEASE INITIAL EACH PARAGRAPH

1. I, _____, understand **I am ultimately financially responsible** for the professional services that I am about to receive. I promise to pay for these charges in a timely manner. I realize that as a service to their patients, Balance Rehabilitation, Inc. (Balance) will bill my insurance company for services rendered. I understand that it is the policy of Balance to try every possible means to receive payment from my insurance company, but **if** in fact, they are unable, that I will be personally responsible for any usual, customary, or reasonable balance that may exist.

2. I, _____, understand that it is **my own responsibility to understand my insurance coverage** as it relates to the services I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card that I can call at any time to ask any questions regarding coverage, eligibility, exclusions, deductibles, co-pays, or any other inquiry I may have. I understand that Balance in no way has any power to dictate policy or procedure of my own insurance company.

3. I, _____, understand that **my own insurance company** decides what to reimburse Balance only after bills are submitted and reviewed. Balance has no authority or ability to decide what treatments will/will not be paid nor at what price. Only my insurance company knows this information once bills are submitted.

4. I, _____, understand that if **I have chosen to purchase an insurance policy with a large deductible**, Balance was in no way a part of that decision and cannot be expected to offer discounts because of this predictable and personal financial decision.

5. I, _____, understand that **late cancellations and no-show** appointments will be subject to a \$25.00 charge. I also realize that any future appointments scheduled will need to be rescheduled as to allow choice of timeslots for more consistent patients.

6. I, _____, understand that for **privacy and safety** concerns, Balance cannot allow anyone other than the patient to be in the treatment area. A family member is welcome to observe during the initial evaluation.

Anyone accompanying the patient after the initial evaluation must wait in the waiting room.

7. I, _____, understand that if my insurance policy has a **deductible larger than \$400**, and **my own** insurance company says that it has not been met, that I will need to pay \$150 for the first visit, and \$100 thereafter until my deductible has been met, before services are rendered.

8. I, _____, understand that being on time, dressed for therapy with comfortable attire, and mobile phones quiet, will help all of us provide and receive the best therapy possible.

Assignment of Benefits

I have read and I agree with the above policies. I hereby authorize my insurance benefits to be paid directly to BALANCE REHABILITATION, Inc. I also authorize BALANCE REHABILITATION, Inc. to release any necessary information to process this claim.

Signature

Date

BALANCE REHABILITATION, INC. NOTICE OF PRIVACY PRACTICES

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

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights.

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. A complete copy of our privacy practices is available at any time in our waiting room or upon request. If you have any questions about this notice please contact the following Privacy Officer.

Effective Date of this Notice: 04/14/03
Contact Person: Mark Wegener – Privacy Officer
25971 Pala #110 Mission Viejo, California 92691
(949) 465-9500 E-mail mark@balancerehab.net

PLEASE INITIAL:

_____ I hereby acknowledge that I have had the opportunity to review a copy of this practice's *NOTICE OF PRIVACY PRACTICES*. I understand that if I have questions or complaints regarding my privacy rights that I may contact the privacy officer. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way during my course of treatment.