PRINT

RESET FORM

Gillette & Associates PHYSICAL THERAPY

PATIENT INFORMATION

Appt Date: _____
Account #: _____
(For Office Use Only)

Patient Name: _____ Social Security Number: _____
Last First MI

Address: _____
Street City State Zip

Phone Home: _____ Cell: _____

Sex: Male ☐ Female ☐ Marital Status: M ☐ S ☐ D ☐ W ☐ Birth Date: _____/_____/_____

Employer: _____ Employer Phone Number: _____

Employer Address: _____

Driver License#/State: _____ May a representative contact you at work ☐ Yes ☐ No

E-Mail Address: _____ May we contact you by e-mail: ☐ Yes ☐ No

Emergency Contact: _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self, ☐ Spouse, ☐ Parent, ☐ Other: _____

Name: _____ Social Security Number: _____
Last First MI

Address: _____
Street City State Zip

Phone Home: _____ Work: _____ Cell: _____

Sex: Male ☐ Female ☐ Birth Date: _____/_____/_____

Employer: _____ Employer Phone Number: _____

INJURY INFORMATION

Accident: ☐ None ☐ W/C ☐ Auto ☐ Other: _____ Injury Onset: _____

Accident Details: _____ Surgery: ☐ Yes ☐ No Date: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

Policy/Claim Number: _____ Group Number: _____

Group Name: _____ Insured Name: _____

Authorization/Pre certification number: _____

Secondary Insurance: _____ Phone Number: _____

Policy/Claim Number: _____ Group Number: _____

Group Name: _____ Insured Name: _____

REFERRAL INFORMATION (For Office Use Only)

Referring Physician: _____ NPI: _____

Phone Number: _____ Fax Number: _____

Prescription Date: _____ Freq & Duration: _____

Diagnosis/Rx Area: _____ Next MD Appt: _____

Intake Completed by: _____ Date: _____

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Past Medical History Form

Date:_____

Patient Name: _____ Referring Doctor: _____

Was this injury the result of an: ☐ Auto Accident ☐ Work Related Injury ☐ Other: _____

Please check and describe the results of any Medical Treatment or Diagnostic Tests performed for this injury.

- ☐ Physical or Occupational Therapy: _____
- ☐ Chiropractics: _____
- ☐ Acupuncture: _____
- ☐ Splinting, Cast, or Brace _____
- ☐ Epidural or Trigger Point Injections _____
- ☐ X-Rays, MRI, CT Scan: _____
- ☐ EMG/NCV tests: _____
- ☐ Bone Density: _____
- ☐ Home Health Services: _____

Do you currently have or have you ever had any of the following?

- ☐ Congestive Heart Failure (CHF)
- ☐ High Blood Pressure
- ☐ Have you had a Heart Attack (MI)
- ☐ Atherosclerotic Disease (CAD)
- ☐ Angioplasty
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Stents or Angioplasty
- ☐ Chest Pain (Angina)
- ☐ Cardiac Arrhythmia's
- ☐ Valvular Disease
- ☐ Do You Have a Pacemaker
- ☐ Stroke (CVA)
- ☐ Shortness of Breath with Exertion
- ☐ Diabetes
- ☐ Cancer, Chemotherapy/Radiation Therapy
- ☐ Frequent, Severe Headaches
- ☐ Difficulty with your Vision or Hearing
- ☐ Bowel or Bladder Incontinence
- ☐ Hernia
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia/Chronic Fatigue Syndrome
- ☐ Sleeping Problems
- ☐ Recent Unexplained Weight Loss
- ☐ Constant Pain at Night
- ☐ Dizziness or Fainting
- ☐ Muscle Weakness or Fatigue
- ☐ Arthritis, Prolonged Predisone use
- ☐ Osteoporosis/Osteopenia
- ☐ Other: _____
- ☐ Other: _____

Please indicate if you have had any of the following Orthopedic Conditions, if so please describe the extent of your injury or surgery.

- ☐ Neck/Back Injury or Surgery: _____
- ☐ Shoulder Injury or Surgery : _____
- ☐ Knee/Hip Injury or Surgery: _____
- ☐ Leg/Foot /Ankle Injury or Surgery: _____
- ☐ Elbow/Hand Injury or Surgery: _____

Are you currently taking any prescription or over the counter medication? ☐ Yes ☐ No

- ☐ Anti Inflammatory Drugs
- ☐ Sleeping Aids
- ☐ Pain or Muscle Relaxants
- ☐ Prednisone or Cortisone

Please list other medications: _____

_____

What are your treatment goals: _____

_____ _____ _____

Patient Signature Therapist Signature Date

Gillette & Associates PHYSICAL THERAPY

CONSENT FOR TREATMENT

I, _____, agree and give my consent for Gillette and Associates Physical Therapy, P.C. to provide physical therapy care and treatment as necessary for your medical condition.

Patient or Responsible Party: _____ **Date:** _____

BENEFIT ASSIGNMENT AND INFORMATION RELEASE

I assign all physical therapy benefits to which I am entitled, including Medicare, Private Insurance, and Third Party Payers to Gillette and Associates Physical Therapy P.C... I authorize Gillette and Associates Physical Therapy, P.C. to release any information including physical therapy and billing records required to secure payment. Please note that a photocopy of this document will be considered valid as the original.

Patient or Responsible Party: _____ **Date:** _____

FINANCIAL POLICY STATEMENT

As a courtesy, Gillette and Associates Physical Therapy, P.C. will bill your insurance carrier. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days of service, you are responsible to pay any remaining balance. In the event that your insurance company requests a refund of payment, you will be responsible for the amount of money refunded to your insurance company. If payment is made directly to you by your insurance company carrier, for services billed by Gillette and Associates physical Therapy P.C., you are responsible to remit full payment to Gillette and Associates Physical Therapy, P.C. If your insurance company finds your service not medically necessary after we bill, you are still responsible for your bill in full. The above may not apply to those patients who are covered by Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Gillette and Associates Physical Therapy, P.C. will verify benefits as a courtesy to you. However, Gillette and Associates Physical Therapy, P.C. does not accept responsibility for any incorrect information given to you or by your insurance carrier regarding the amount of your co-payment, co-insurance benefits or benefit plan.

When you pay by check, you authorize Gillette and Associates Physical Therapy, P.C. If your check is returned for any reason, you will be responsible for the amount of the check plus any applicable California State processing fees. Please note that your signature authorizes an electronic debit to your account for any state allowed recovery fees. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke this authorized transmission. This will not prevent Gillette and Associates Physical Therapy, P.C. from pursuing other methods of collecting a returned check fee.

I understand and agree that I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs associated with collecting money owed by me including court costs, collection agency fees and attorney fees.

INFORMATION PRIVACY

Gillette and Associates Physical Therapy, P.C. will use and disclose your personal health information to treat you and to receive payment for services rendered. A notice of Privacy Practices is posted in the clinic. It is available on our website and is available upon request in the clinic. The undersigned acknowledges receipt of this information.

I UNDERSTAND AND ACCEPT MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Patient or Responsible Party: _____ **Date:** _____

Gillette and Associates Physical Therapy, P.C. Rep: _____ **Date:** _____

Gillette and Associates Physical Therapy Notice of Privacy Practices

Privacy Officer: Terry Gillette Effective Date: 1-2-06

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.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms or the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please let us know.

WHO WILL FOLLOW THIS NOTICE: Any health care professional authorized to enter information into your medical record, all employees and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g., a billing service) sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we may use and disclosed medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have any medical conditions that could influence which treatments we prescribe for your rehabilitation.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you received from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS: We my use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures that can be Made Without Consent or Authorization:

- As required during and investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a corner or medical examiner for identification of a body
- If an inmate, to the correctional institute or law enforcement official
- As required by the US Food and Drug Administration
- Other healthcare providers' treatment activities
- Other covered entities and providers payment activities
- Other covered entities healthcare operation activities (to the extent permitted under HIPAA)
- Uses and disclosures provided by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activates
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other related benefits and services that may be of interest to you.

Gillette and Associates Physical Therapy Notice of Privacy Practices

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization. Other uses and disclosures of medical information not covered by the notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, w will thereafter no longer use or disclose medical information about you for the reasons covered by our written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of that care we have provided you.

Your Individual Rights Regarding Your Medical Information Complaints: If you believe your privacy rights have been violated, you may file a complaint at this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

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, treatment or healthcare operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request, unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to us. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. We will not ask you the reason for your request. We will accommodate all reasonable request. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this included medical billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to this practice. If you request a copy of the information, we reserve the right to charge a fee for the cost of copying, mailing or supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information kept. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to this practice. In addition, you must provide a reason that supports your request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement or disagreement with us. We may prepare rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements or disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years. The first list you request with a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

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 revise or change this Notice effective for medical information we already have about you as well as any information we receive in the future.

Gillette and Associates Physical Therapy
6325 Topanga Canyon Blvd. Suite 100
Woodland Hills, CA 91367
(818) 340-8858

Gillette & Associates PHYSICAL THERAPY

Release from Home Health Care

Date: _____

Patient Name: _____

I am currently **NOT** receiving Home Health Care Services (Physical, Occupational and or Speech Therapy, Nursing, or Attendant care) that is being paid by my insurance company.

If payment for the Physical Therapy services provided by Gillette and Associates Physical Therapy are denied by my insurance company due to having concurrent Home Health Care Services, I understand that I will be responsible for payment in full.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date

Gillette & Associates PHYSICAL THERAPY

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Gillette and Associates Physical Therapy P.C, Privacy Notice of Information Practices. I understand that Gillette and Associates Physical Therapy P.C. 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 Gillette and Associates Physical Therapy P.C... I also understand that Gillette and Associates Physical Therapy P.C will consider requests for restriction on a case by cases basis, but does not have to agree to request restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted by Gillette and associates P.C. Privacy Notice of Information Practices.

I understand that I retain the right to revoke this consent by notifying Gillette and Associates Physical Therapy P.C in writing at any time.

_____

Patient Name (please print)

_____

Signature of Patient or Responsible Party

_____

Date