PATIENT INFORMATION

Name:_____ M / F Date of Birth: ____/_____/_____ Age:_____
Last First M.I.
Social Security No: _____ - _____ - _____ Driver's License Number:_____ Married:__ Single: __ Other:__

Address:_____
Street City State Zip

Email:_____

Home: (_____)_____Cell: (_____)_____ Employed: Y / N F/T P/T Student
Preferred Contact Phone No.: ☐Home ☐Cell ☐Work

Employer:_____ Occupation:_____ Work Phone:(____)_____

Work Address: _____

Spouse: _____ Social Security No:____-____-_____ DOB: ____/_____/____

Emergency Contact: _____ Phone: (_____)_____

Relationship to Patient: _____

Referring M.D.: _____ Phone: (_____)_____

Previous Therapy & Location: _____Date:_____

Date of Injury or Onset: _____/_____/_____ Body Part(s) Injured: _____

Did you sustain the injury at Work? Y N Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N Is your spouse or other family member employed? Y N

☐ Auto accident ☐ other:_____ Do you have a secondary Insurance Policy? Y N

If this was an auto accident in what U.S. State did it take place?: _____

Attorney Name:_____ Attorney Phone number: _____

Name of Insured: _____ Relationship to Patient: _____

Address of Insured:_____
□If same as patient's address
Date of Birth:____/____/____ Employer: _____ Social Security No:____-____-_____

Primary Health Ins: _____ **Secondary Health Ins**: _____

ID No.:_____ Group No:_____ ID No.:_____ Group No:_____

****As a courtesy, we will check your insurance benefits. You will be able to obtain a copy of the quote we received from your insurance company upon request. This is NOT a guarantee of eligibility or payment, actual payment is based on the terms and conditions of the plan. All claims are subject to review upon submission.****

I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian if Under 18)

Patient Questionnaire

Patient Information Record

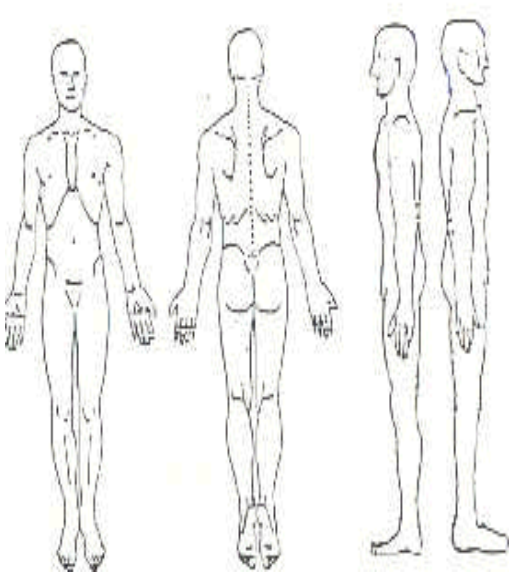
1. Name: _____ Height: _____ Weight: _____

2. Date of onset of symptoms: _____
3. What caused the symptoms? _____
4. What is your biggest complaint? _____
5. What activities could you perform before, that you cannot now due to your condition? _____
_____
6. Do you have any symptoms of tingling, burning or numbness? □ yes □ no Where? _____
7. Any changes in Bowel or Bladder function? □ yes □ no
8. Which activities make your symptoms worse? _____
9. What makes your symptoms better? _____
10. Do your symptoms change throughout the day? □ yes □ no
11. Have you had similar episodes before? □ yes □ no
12. Are these episodes increasing in frequency, severity and or character? □ yes □ no
13. What is the usual cause for recurrent problems? _____
14. Have you had surgery for this condition? □ yes □ no If yes, Date of Procedure: _____
15. Have you been treated or is any other health care practitioner currently treating these symptoms? □ yes □ no
16. If yes, please provide their name (s) and telephone number(s): _____
_____
17. Have you had any recent diagnostic tests performed regarding your present condition (x-rays, MRI, etc.)? □ yes □ no
18. If yes, what were the tests and when were they performed? _____
_____
19. Alcohol consumption: Average drinks per Day: _____ Week: _____

Medical History

1. What medications are you currently taking, if any? _____
_____
2. What allergies do you have, if any? _____
_____

3. Do you have a history of diabetes? □ yes □ no
4. Do you have a history of heart disease? □ yes □ no
5. Do you have a history of high blood pressure? □ yes □ no
6. Is it under control? □ yes □ no
7. Have you had previous head trauma or repeated convulsions? □ yes □ no
8. Have you had surgery for head, neck or spine? □ yes □ no
9. Have you had abdominal surgeries? □ yes □ no
10. Have you had any previous shoulder injuries? □ yes □ no
11. Have you had any previous knee injuries? □ yes □ no
12. Have you had any previous ankle injuries? □ yes □ no
13. Have you had any fractures? □ yes □ no
14. Are you currently pregnant? □ yes □ no
15. Have you been diagnosed with osteoporosis? □ yes □ no
16. Have you been diagnosed with rheumatoid arthritis? □ yes □ no
17. Do you have a personal history of cancer? □ yes □ no
18. Do you have glaucoma? □ yes □ no
19. What exercise / sports do you participate in?



_____
20. Do you know of any reason why you should not participate in a regular exercise program? □ yes □ no if yes, why? _____
_____
21. Is there any other medical condition or diagnosis we should be aware of? □ yes □ no if yes, what is it? _____
_____

Signature: _____ **Date:** _____

Assignment of Benefits Form

Patient:_____ Employer: _____

Ins. Group: _____ SS# / ID#: _____

I hereby authorize my Insurance Company to pay by check made out and mailed to: **Westlake Physical Therapy, Inc.**

OR

If my current policy prohibits direct payment to medical provider, I hereby authorize you to make out the check to me and mail it as follows:

Patient Name:_____

C/O Westlake Physical Therapy, Inc.
1220 La Venta Dr. Ste. 102
Westlake Village, CA 91361

For the professional or medical expense benefits allowed by my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. **I understand that I am responsible for any balance of charges not covered by my insurance company which include the deductible & co-insurance**.

-A photocopy of this Assignment shall be considered as effective and valid as the original.

-I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

-I authorize Westlake Physical Therapy, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

ATTENTION PATIENTS!!!

- ALL COPAYS & CO-INS AMOUNTS MUST BE PAID PRIOR TO SEEING THE PHYSICAL THERAPIST
- IF YOU HAVE A **HIGH DEDUCTIBLE** POLICY, **PAYMENT IS DUE AT THE TIME OF SERVICE!**
- IF YOU ARE A NEW PATIENT AND/OR IT HAS BEEN 1 YEAR OR MORE SINCE YOUR LAST VISIT THE FOLLOWING WILL BE REQUESTED:
  - NEW INFORMATION PACKET
  - COPY OF INSURANCE CARD
  - COPY OF PHOTO IDENTIFICATION

IF THIS INFORMATION IS NOT OBTAINED WE MUST RE-SCHEDULE YOUR APPOINTMENT.
(NO EXCEPTIONS)

IT IS YOUR RESPONSIBILITY TO NOTIFY THE RECEPTIONIST IF YOUR INSURANCE COMPANY HAS CHANGED. IF YOU FAIL TO NOTIFY US PRIOR TO YOUR OFFICE VISIT, YOU WILL BE RESPONSIBLE FOR ALL PHYSICAL THERAPY CHARGES ASSESSED. PLEASE DIRECT ANY QUESTIONS REGARDING OUR INSURANCE TO THE RECEPTIONIST.

THANK YOU!!!

_____ _____

Signature of Patient or Legal Guardian (if under 18) Date

_____

Witness

2024 Medicare Cap on Therapy Services

Home Health Services & Outpatient Therapy

Patient's Name: _____

☐ Yes ☐ No	Are you currently receiving ANY home health services? These may include but are not limited to visits to your house by: doctors, nurses, physical / speech / occupational / respiratory / cardiac therapists, lab technicians, nutritionists or any personnel assisting with care of daily living.
☐ Yes ☐ No	Have you received ANY home health services (nursing, therapy, etc...) in the last six months? If Yes, Agency Name: _____ Phone Number: _____ Date services ended:_____
☐ Yes ☐ No	Have you signed over your Medicare benefits to an HMO?

2024 Therapy Cap Summary:

Medicare has placed a financial limitation of $2,330.00 on the amount of therapy an individual can receive in 2024. This therapy cap applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs), and comprehensive outpatient rehabilitation facilities (CORFs), and outpatient hospital department services for dates of service from January 1, 2024 through December 31, 2024. The cap excludes inpatient hospital services provided at hospitals. The cap is based on the Medicare allowed fees.

Based on our typical visit patterns, you may reach the cap after about 22 visits. In 2023 we averaged 20 visits per Medicare patient. If you get close to reaching the cap we will review the available options with you.

We believe that continuity of care is critical to reaching maximum function and returning you to an active lifestyle. Therefore, we have developed special programs to assist our patients that have reached the cap in continuing care here at Westlake PT. We will keep you informed about your options.

☐ Yes ☐ No	Have you received ANY outpatient physical therapy services since January 1, 2024? If Yes, indicate: Where: When:
☐ Yes ☐ No	Have you received ANY speech-language pathology services since January 1, 2024? If Yes, indicate: Where: When:

I am aware that if I am receiving ANY type of HOME HEALTH SERVICES I am NOT eligible for outpatient physical therapy. _____ (Initial)

My signature below indicates that I have read and understand the above information and have had all my questions answered.

Signature:	Date:

Appointment Agreement Form

Our facility would like to emphasize the importance of regularly scheduling and making set appointments. For your health and for the success of your treatment, we ask that you adhere to your Physician and Therapists recommendations for treatment frequency and duration, to the best of your ability.

Late Cancellation and No-Show Policy
Under the guidelines of this facility a "Late Cancelled" appointment occurs when a patient gives less than 24 hours notice for canceling or re-scheduling a set appointment. A "No-Show" is when a patient breaks an appointment with no prior notice. Due to the volume of business and our desire to provide patients with the best service possible, every appointment is greatly valued; therefore when appointments are cancelled or broken, our patients, as well as our therapists are at a loss. We know that your time is valuable, and we pride ourselves with prompt and close attention to each of our valued patients. Please in turn be considerate of our time, and keep all scheduled appointments if physically able.

All Late Cancellation or No-show will be documented in the patients chart. The patient will be made aware of the documentation either in a written or verbal communication from our staff.

Any instances of Late Cancellations or No-Shows will be subject to a **$50** fee upon each occurrence, depending on circumstances and Management discretion.

If the behavior is continued to an extent considered inappropriate or unmanageable by the therapist or management, the patient will be discharged from care at this facility and referred back to their Physician.

By signing and dating this form, I acknowledge that I have read and understand the aforementioned procedures and policies of this facility and agree to these terms. I understand that a fee may be applicable for canceling or breaking an appointment according to set guidelines. _____ (Initials)

****

Acknowledgement of Receipt of

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this Physical Therapy office's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice will be in the reception area of this Physical Therapy office. If amended, I will be provided with a copy of the amended notice will also be available in the reception area updating the original.

****

Signed: _____ Print Name: _____

Date: _____ Telephone: _____

If not signed by patient please indicate:

_____ Parent/guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of a deceased patient

NOTICE OF PRIVACY PRACTICES

Westlake Physical Therapy, INC.
1220 La Venta Dr. Suite 102 Westlake Village, CA 91361
110 Jensen Ct. Suite 2C Thousand Oaks, CA 91360
Aaron Molinar – Administrator (805) 777-7370 (Privacy Officer)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE

Understand Your Physical Therapy Health Record Information

Each time that you visit a hospital, physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:
-Basis for planning your care and treatment.
-Means of communication among the many health professionals who contribute to your care.
-Legal document describing the care that you received.
-Means by which you or a third-party payer can verify that you actually received the services billed for.
-Tool in medical education.
-Source of information for public health officials charged with improving the health of the regions that they serve.
-Tool to assess the appropriateness and quality of care that you received.
-Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health record and how your health information is used helps you to:
-Ensure its accuracy and completeness.
-Understand who, what, where, why and how others may access your health information.
-Make informed decisions about authorizing disclosure to others.
-Better understand the health information rights detailed below.

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A. Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the healthcare provider who completed the records, you have the following rights with regard to the information contained therein:

1. Right to request Special Privacy Protections. Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restrictions does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communication on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purpose of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.
2. Right to inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
-Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical records.
-Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
-Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42U.S.C. 263a, to the extent that giving you access would be prohibited by law.
-Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.
-Information that is copyright protected, such as certain raw data obtained from testing.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
-A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgement, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
-PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
-The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.
For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost based fee for making copies.

3. Right to request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
a. We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
b. The records are not available to you as discussed immediately above.
c. The record is accurate and complete.

4. Right to obtain an accounting of non-routine uses and disclosures. For those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures for treatment, payment, and health care operations under certain circumstances, primarily if we maintain an electronic health record. We do not need to provide an accounting for the following disclosures:
a. To you for disclosures of protected health information ("PHI") to you.
b. For the facility directory or to persons involved in your care or for other notification purposes as provided in 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care of your location, general condition, or death).
c. For national security or intelligence purposes under 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
d. To correctional institutions or law enforcement officials under 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
e. That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include the following information:
f. Date of each disclosure.
g. Name and address of the organization or person who received the protected health information.
h. Brief description of the information disclosed.
i. Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

5. Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

6. Right to obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.

B. Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:
-Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
-Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
-Abide by the terms of this notice.
-Train our personnel concerning privacy and confidentiality.
-Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regards thereto.
-Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. These include most uses or disclosures of psychotherapy notes, marketing communications, and sales of PHI. Other uses and disclosures *not described in this notice* will be made only with your written authorization.

C. Examples of Disclosures for Treatment, Payment, and Health Care Operations

We may use your health information for treatment.
Example: a physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of you records to assist them in treating you once we are no longer treating you. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

We may use your health information for payment
Example: we may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

We may use your health information for health care operations
Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

Business associates
We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010 business associates must comply with the same federal security and privacy rules as we do.

Directory
Unless you notify us that you object, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and except for religious affiliation, to other people who as for you by name.

Notification
We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.

Communication with family

Unless you object, we, as health professionals, using our best judgement, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors

We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If we contact you to provide marketing information for other products or services, you have the right to opt out of receiving such communications. Contact the office at (805) 777-7370. If we receive compensation from another entity for the marketing, we must obtain your signed authorization.

Fundraising

We may contact you as a part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials. Contact the office at (805) 777-7370.

Food and Drug Administration ("FDA")

We may disclose to the FDA health information relative to adverse/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institutions

If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Health oversight agencies and public health authorities

If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the Department of Health.

The federal Department of Health and Human Services ("DHHS")

Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

D. When This Practice May Not Use or Disclose your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

E. Changes to this Notice Privacy Practice

We reserve the right to amend this Notice of Privacy Practice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website www.WestlakePhysicalTherapy.com

F. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, suite 4-100
San Francisco CA
(415) 437-8310; (415)437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized for filing a complaint.