Express Registration

exhalept
PHYSICAL THERAPY & PILATES

Please Fill-Out Entire Form Completely and Legibly.

Today's Date:

1. Patient Info

☐ Male
☐ Female
☐ Other

Last Name ____ First Name ____ Age ____

Street Address ____ City ____ State ____ ZIP ____

Home Phone ____ Cellular ____ Email Address ____
(Required in order to watch "New Patient Video")

Occupation ____ Employer Name ____ Phone # ____

Emergency Contact Person ____

If Patient is a MINOR: Parent/Guardian Name and Signature Here ____

Social Security # ____

☐ Single ☐ Married

Date of Birth ____

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (___Total or ___Temporary)
☐ Student (___P/T___F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

☐ AUTO/PERSONAL INJURY: Date of accident:
__ /__/ __

☐ WORK INJURY: Complete all information below.

Date of injury: __ /__/__

Your company HR person name ____

Insurance adjustor name ____

Insurance adjustor PH# ____

☐ NO INJURY: What do you think may have caused it?

I have already had . .

☐ SURGERY: When and what type?

☐ PHYSICAL THERAPY BEFORE: When and where?

☐ HOME HEALTH CARE: Are you still receiving it?
___ YES ___ NO

☐ OTHER care: What?

3. Payment Info

(check only one box)

I am paying TODAY by . . .

☐ ***INSURANCE*** *and would like to . . .*

___ Have you deal directly with them. I will assign my benefits to you by completing the ***"Assignment of Benefits Form"*** (Fees may apply in some cases) The following information is required prior to 1st visit.

My coinsurance/copay is $ ___

My deductible is $ ___

☐ ***WORKERS COMP***
You must have all info provided under "My Condition...".

☐ ***CASH, CHECK, CREDIT*** and would like a . . .
Payment plan and apply for "Financial Hardship"

☐ i have an ***ATTORNEY*** and would like to . . .
___ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply

4. Referral Info

How did you hear about us?

☐ Friend or Family: ☐ Brochure: ☐ Give details:
☐ Internet ☐ Insurance/Directory:
☐ Advertisement ☐ Other:

☐ Physician/Dentist/Chiropractor/Nurse: Give details below.

Referring Physician/Person's Name ____

City ____ State ____

Phone # ____

☐ I have read and agree to all the policies on the back of this form.

Signature ____

© 2017 Exhale Physical Therapy Corp.

Company policies

exhalept
PHYSICAL THERAPY & PILATES

Initial All Boxes

We strive to provide you with the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully and initial all the boxes to indicate your agreement.

Late Policy "15 Minutes"

Being late by more than 15 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since opening due to cancellations are unpredictable. We do not allow appointment overlaps because this undeservedly compromises the care of another patient.

24-hour advance notice fee

If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a $55 fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc). We don't charge you the actual cost for that appointment but rather a lesser $55 fee. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

Copays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

No-shows Are bad

If you fail to show for an appointment without notice all future appointments will be removed and a $50 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis."

Cell phones must be shut OFF or silent

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

Children requiring supervision are NOT allowed to attend sessions with you

You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child

Important notice from the Federal Government

"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments... even if your doctor allows it. Unless you complete a "Financial Hardship" form. and qualify for financial assistant under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays." Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountibillity Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Departamnet of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspoector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, SW., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspecttor General, 202-619-0089

We look forward to buildng a successful relationship with with you that lasts a lifetime!

© 2017 Exhale Physical Therapy Corp.

Pre-Exam Questionnaire exhalept

PHYSICAL THERAPY & PILATES

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. What is your age? ____________________
2. What is your gender? ☐ Male ☐ Female ☐ Other
3. What is your occupation? ____________________
   a. Are you working now? ☐ Yes ☐ No
4. Have you had physical therapy before? ☐ Yes ☐ No
5. Where is your pain/problem? ____________________
6. What caused your pain/problem? ____________________
7. Approximately when did it start? ____________________
8. Is it getting worse, better or staying the same? ☐ Yes ☐ No
9. Have you ever had this pain/problem before? ☐ Yes ☐ No
10. Is your pain constant (never goes away)? ☐ Yes ☐ No
11. On the scale below circle your worst pain level in the past couple of days:

Mild *Moderate* *Severe*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9. . . 10

1. Are you taking any medication for this problem? ☐ Yes ☐ No
   a. If yes, what and does it help?
2. Are any of your usual everyday activities affected? ☐ Yes ☐ No
   a. If yes, describe how.

14. List all past surgeries with dates:

15. List all medical conditions you have (or were told you have):

Patient's Name (print)

____

Patient's Signature ____________________________________ Date: ____________________

© 2017 Exhale Physical Therapy Corp.

Informed Consent/Policies Agreement

exhalept
PHYSICAL THERAPY & PILATES

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1. Does your condition interfere with the quality of your life?
2. Does your condition interfere with your ability to perform work or daily activities?
3. Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4. Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or your ability to perform daily activities to improve through modified movement, assistive devices, ect.?
5. Are there specific goals set that are measurable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as 830laser, massage, myofascical treatments, fitness/exercise training, Pulsetron, Posture Program, ect. payable out-of-pocket by cash, check, or credit card.

Cancel/No-Show/Late

Please refer to the Express Registration Form.

Authorization for Release of Records Assignment of Benefits

(for insurance patients)

Please refer to the Assignment of Benefits Form.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums and exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless the diagnosis is exempt from the Cap)

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises, or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatment ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

Patient's Signature/Date

____

Witness Signature/Date

____

Patient's Representative Signature/Date

____

Relationship to patient

____

© 2017 Exhale Physical Therapy Corp.

Statement of Privacy Notice

exhalept
PHYSICAL THERAPY & PILATES

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 may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We may disclose your health information to your insurance provider for the purpose of payment or health care operations. We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes. We may disclose your health information to coroners or medical examiners. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes. We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
You have the right to inspect and copy your health information.

You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

© 2017 Exhale Physical Therapy Corp.

Statement of Privacy Notice

You have a right to receive an accounting of disclosures of your protected health information made by us. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at
(310) 896-8763. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (310) 869-8763. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ______________________________
Patient's Signature Date:

____ ______________________________
Authorized Facility Signature Date:

© 2017 Exhale Physical Therapy Corp.

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AND PARENTAL CONSENT AGREEMENT

IN CONSIDERATION of being permitted to participate in the PHYSICAL THERAPY PROGRAM ("Activity") I, for myself for family, friends, representatives, assigns, heirs, and next of kin:

ACKNOWLEDGE, agree, and represent that I understand the nature of PHYSICAL THERAPY Activities and that I am qualified, in good health, and in proper physical condition to participate in such Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.
FULLY UNDERSTAND THAT: PHYSICAL THERAPY ACTIVITIES INVOLVE RISKS AND DANGERS OF SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS, AND DEATH ("RISKS"); (b) these Risks and dangers may be caused by my own actions or inaction's, the actions or inaction's of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE "RELEASEES" NAMED BELOW; (c) there may be OTHER RISK AND SOCIAL AND ECONOMIC LOSSES either not known to me or not readily foreseeable at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES I incur as a result of my participation or that of the minor in the Activity.
HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE EXHALE PHYSICAL THERAPY, INC. OR their respective administrators, directors, agents, officers, members, volunteers, and employees, other participants, any sponsors, advertisers, and, if applicable, owner and lessors of premises on which the Activity takes place, (each considered one of the "RELEASEES" herein) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS AND I FURTHER AGREE that if, despite this RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT I, or anyone on my behalf, makes a claim against any of the Releasees, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES from any litigation expenses, attorney fees, loss, liability, damage, or cost which may incur as the result of such claim.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Printed Name of PATIENT/PARTICIPANT: ____

Address: ____
(Street) (City) (State)(Zip)

Phone: ____

PATIENT/PARTICIPANT Signature (Only if age 18 or over. If minor, please see next page):

____

Date: ____

© 2017 Exhale Physical Therapy Corp.

MINOR RELEASE

AND I, THE MINOR'S PARENT AND/OR LEGAL GUARDIAN, UNDERSTAND THE NATURE OF PHYSICAL THERAPY ACTIVITIES AND THE MINOR'S EXPERIENCE AND CAPABILITIES AND BELIEVE THE MINOR TO BE QUALIFIED, IN GOOD HEALTH, AND IN PROPER PHYSICAL CONDITION TO PARTICIPATE IN SUCH ACTIVITY. I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS EACH OF THE RELEASEE'S FROM ALL LIABILITY CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON THE MINOR'S ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATION AND FURTHER AGREE THAT IF, DESPITE THIS RELEASE, I, THE MINOR, OR ANYONE ON THE MINOR'S BEHALF MAKES A CLAIM AGAINST ANY OF THE RELEASEES NAMED ABOVE, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES FROM ANY LITIGATION EXPENSES, ATTORNEY FEES, LOSS LIABILITY, DAMAGE, OR COST ANY MAY INCUR AS THE RESULT OF ANY SUCH CLAIM.

Printed Name of PARENT/GUARDIAN: ______________________________
Address: ______________________________
(Street) (City) (State)(Zip)

Phone: ______________________________

PATIENT/PARTICIPANT Signature (Only if age 18 or over. If minor, please see next page):

______________________________ Date: ______________________________

© 2017 Exhale Physical Therapy Corp.