Back to Life Physical Therapy, Inc.

KAISER PATIENT
INFORMATION FORM

Name _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Age: _____

Kaiser MRN _____

Phone (Best number to reach you) _____ (home/work/cell – circle one)

Phone (Alternate) _____ (home/work/cell – circle one)

Email Address _____

Employer _____

Job Title _____

Emergency Contact Name _____

Emergency Contact Phone _____

Emergency Contact's Relation to You _____

Primary Physician _____

Referring Physician _____

Brief description of your symptoms _____

Have you had surgery related to the condition for which you are coming to physical therapy? _____

If yes, please list, with dates: _____

_____

Have you previously had physical therapy for this or other conditions? _____

Please describe: _____

_____

PREVIOUS MEDICAL HISTORY

Please indicate yes if you have now, or have previously had, any of the following:

High blood pressure	_____	Pregnancies	_____
Low blood pressure	_____	Depression	_____
Heart disease	_____	Asthma	_____
Cancer	_____	Emphysema	_____
Diabetes	_____	Thyroid disorder	_____

Other medical history (please list): _____

_____

_____

_____

Allergies (please list – if any): _____

_____

Surgeries (please list, with dates - even if they seem unrelated):_____

_____

_____

_____

Musculoskeletal injuries/strains other than those for which you are coming to physical therapy (Please list - even if they seem unrelated): _____

_____

_____

_____

Medications (please list): _____

_____

_____

_____

Have you experienced previously the condition for which you are seeking treatment?_____(yes/no)
If yes, please describe how frequently, whether you have sought treatment, and if so, what type of treatment. _____

_____

_____

_____

POLICIES AND CONSENTS

Welcome

Our goal at Back to Life is to provide you with precise, effective and compassionate physical therapy. Please take the time to read the following office policies carefully and to then sign the statements of consent.

Financial Policy

You are responsible for your co-pay per your Kaiser policy. This is due either prior to or on the day of your appointment.

Appointment Policy

You are responsible for scheduling your appointments.

Appointments are scheduled for one hour each. 55 minutes is spent one on one in the physical therapy session. The treatment schedule is booked so that you will not be kept waiting. Failure to arrive at your scheduled appointment time will result in less time available for your treatment.

Appointment cancellations require a minimum of 2 business days' notice. In the case of Monday appointments, please call by Thursday, and for Tuesday appointments, please call by Friday.

You will be responsible for confirming your appointment prior to 48 hours before your scheduled appointment time. If you do not confirm, Back to Life reserves the right to fill your appointment with another patient. If you must cancel a session without 48 hours notice, Back to Life reserves the right to prioritize other patients in the future for scheduling regardless of the reason for your cancellation.

I have read the above policies and agree to comply with them. I authorize release of any information regarding my treatment in this facility to my referring physician.

Patient Signature:_____ Date:_____

Consent to receive services: I hereby authorize Amy Selinger, DPT, OCS, Jessica Manley, PT, DPT and/or Iris Warchall, PT, DPT to render appropriate physical therapy services to me. I recognize and agree that I have the right to refuse treatment or to terminate treatment at any time by notifying Amy, Jessica and/or Iris. In addition, Amy, Jessica and/or Iris may terminate services by notifying me of the termination and reason.

Authorization for Emergency Medical Services: In the event of a medical emergency during physical therapy treatment, I authorize Amy, Jessica and/or Iris to provide or obtain such medical treatment as they deem advisable under the circumstances and I agree to assume sole responsibility for all charges for such treatment.

Patient Signature:_____ Date:_____

Kaiser Permission To Bill

In accordance with the Health Insurance Portability and Accountability Act of 1996, providers must have patient permission to bill third party insurance companies and receive payment from those companies.

As a provider, we must have your signature on file, for audit purposes.

By signing this document, you authorize the release of any medical or other information necessary to process your claims. You are also requesting payment of benefits to the party who provides services (Back to Life) and authorizing them to receive payment for these services indicated in box 12 and 13 on the CMS 1500 claim form.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review The Notice before signing this Consent. The terms of The Notice may change. If we change The Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reference to your prior Consent. Back to Life Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Rights

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review The Notice.
- The Practice reserves the right to change The Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of this HIPAA practice notice.

Consent was completed by: _____

Printed Name of Patient or Representative

Relationship to Patient (if other than patient): _____

Witness: _____

Printed Name of Practice Representative