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Physical Therapy + Advanced Wellness

PATIENT RIGHTS

The following is our policy regarding the rights of the patients receiving service from ***Evolve Physical Therapy + Advanced Wellness***. Each patient has the right to:

A. Be fully informed of his/her rights as well as all rules and regulations of ***Evolve Physical Therapy + Advanced Wellness*** governing patient expectations.

B. Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.

C. Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment.

D. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

E. Be assured confidential treatment of clinical records and to approve or refuse their release to any individuals, except in the case of transfer to another health care facility, or as required by law or third party payment contracts.

F. Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.

G. Be informed by ***Evolve Physical Therapy + Advanced Wellness*** of the provision of the law regarding complaints and of procedures for registering complaints confidentially including, but not limited to the address and telephone number of the complaint receiving unit of the California Department of Health Services.

H. Be assured that personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

I. Be informed that these rights may be denied for good cause only by the attending Physical Therapist. Denial of such rights shall be documented by the attending Physical Therapist in the patient's clinical record.

Any complaints regarding denial of patients rights not satisfied after a discussion with **Evolve Physical Therapy + Advanced Wellness** must be registered in confidence with the California Department of Health Services. Upon request, the staff of **Evolve Physical Therapy + Advanced Wellness** will assist the patient to contact the appropriate office of the state agency.

NOTICE OF PATIENT INFORMATION PRACTICES

****THIS NOTICE DESCRIBES HOW YOUR PERSONAL MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.****

EVOLVE PHYSICAL THERAPY + ADVANCED WELLNESS'S LEGAL DUTY

Evolve Physical Therapy + Advanced Wellness is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Evolve Physical Therapy + Advanced Wellness uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, **Evolve Physical Therapy + Advanced Wellness** may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Evolve Physical Therapy + Advanced Wellness may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, or for emergencies. We also provide information when required by law.

In any other situation, **Evolve Physical Therapy + Advanced Wellness's** policy is to obtain your written consent disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Evolve Physical Therapy + Advanced Wellness may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request a copy of our Notice Of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we are not to use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. **Evolve Physical Therapy + Advanced Wellness** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Evolve Physical Therapy + Advanced Wellness** may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services.

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CLINIC POLICIES

Name: _____ **Date:** _____

Welcome to ***EVOLVE PHYSICAL THERAPY + ADVANCED WELLNESS***. We look forward to serving all of your physical therapy + wellness needs. As a new patient with our office, we would like you to be familiar with our office policies concerning your scheduling and account while you are with us. Please feel free to ask any questions regarding the following.

1. Your insurance dictates whether or not it can be billed without a current prescription from your doctor.

2. You will meet your therapist at your first appointment. Please be ready to begin your appointment at your scheduled time. To be fair to all patients, we will not run over the allotted time period.

3. WE REQUIRE A **48-HOUR NOTICE** TO CHANGE OR CANCEL A SCHEDULED APPOINTMENT DURING OUR BUSINESS HOURS. If you fail to show or cancel your appointment without a **48-hour notice** you will be charged a Late Cancellation or No Show fee. Cancellations made on the weekends are NOT considered a 48-hour notice. The charge is ***$95.00***, for a physical therapy visit. These charges are the patient's responsibility and cannot be billed to your insurance company. **For cash paying visits**: you will be charged for the FULL visit. If you have a pack, it will be the pack price; otherwise, it will be a one time visit price. **Payment of missed appointments will be due on or before your next appointment.**

4. Our office is happy to courtesy bill your insurance. We will also courtesy call your insurance to verify your PT benefits. As your insurance will make no guarantee of payment until the claim is received and processed, you will be financially responsible for all services unpaid by insurance after 60 days. Your insurance company may require authorization or pre-certification for certain procedures and services. As a courtesy, we will contact your insurance company on your behalf. It always remains your responsibility to understand what your insurance policy covers and confirm directly that you have authorization and coverage for services you receive. We may request your direct involvement in following up on our authorization requests and delayed payments if your insurance becomes unresponsive to our inquiries. Direct intervention on the part of the patient often results in a more timely approval of services, prevents delays in treatment, and expedite payment for your services.

5. "Cash Pay" services **can not** be billed to insurance. We the provider and you, the patient, cannot submit these services to your insurance company. We will collect for "Cash Pay" services after each appointment or session. Discounted package services must be purchased in advanced. Our "Cash Pay" services include:
   - ***Acupuncture and Bodywork***
   - ***All therapy supplies and products including: therabands, foam rollers, orthotics, etc.***
   - ***Gym Services***
   - ***Wellness Appointments***
   - ***Classes: 50 Shades, 30 Min Abs***
   - ***Golf Fit Program***

6. The patient's personal portion will be due after every visit and is collected at the front desk. ***Please be advised we are estimating your personal portion***. This is based on the information received when benefits were quoted by your insurance. Final balances will be determined once your insurance finishes processing. At that time,outstanding balances will then be collected or over-payments will be refunded.

7. We do not accept liens or third party payers.

8. In the event any action is taken to enforce collection of this account, the presiding party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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PATIENT INFORMATION CONSENT AND CONSENT TO TREAT FORM

I hereby consent to having ***Evolve Physical Therapy + Advanced Wellness*** treat me.
I have read and fully understand the ***Evolve Physical Therapy + Advanced Wellness*** "Notice of Information Practices." I understand that ***Evolve Physical Therapy + Advanced Wellness*** 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 the practice. I also understand that ***Evolve Physical Therapy + Advanced Wellness*** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in the ***Evolve Physical Therapy + Advanced Wellness***'s "Notice of Information Practices." I understand that I retain my right to revoke this consent by notifying the practice in writing at any time.

_____
PATIENT NAME

_____ _____
SIGNATURE Date

We require a **48-hour notice** to change or cancel a scheduled appointment during our business hours. **If you fail to show or cancel your appointment without a 48-hour notice you will be charged a Late Cancellation or No Show fee of $95.00, for a physical therapy visit.** If you cancel outside of our business hours, it will **NOT** be considered a **48-hour notice**. These charges are the patient's responsibility and cannot be billed to your insurance company. For cash paying visits: you will be charged for the FULL visit. If you have a pack, it will be the pack price; otherwise, it will be a one time visit price. Payment of missed appointments will be due before your next appointment. _____ *(INITIALS)*

It is your responsibility to arrive on time for all of your scheduled appointments. Evolve Physical Therapy + Advanced Wellness will provide you with a complimentary phone call or email to remind you of your upcoming appointments. **Please let us know what form of the reminder you prefer.**

CALL #: _____ TEXT #:_____ Email:_____

OR:

I, _____ would prefer **NOT** to receive a reminder of any sort for my upcoming appointments. I understand that I need to give **48-hour notice for a cancellation or may be subject to a late cancellation or a no show fee of $95.00 for a PT visit or the full value or pack price for any cash service such as massage, gym, acupuncture, etc.**

_____ _____
Signature Date

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This original will be kept in your chart. A copy of this form is available upon request.

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Waiver in Connection with use by Members and Guests of Evolve Physical Therapy + Advanced Wellness

The execution of this form is a condition to use by member and guests of ***Evolve Physical Therapy + Advanced Wellness.*** This form is intended to affect your right to maintain certain claims and legal actions against ***Evolve Physical Therapy + Advanced Wellness*** weight/exercise room in the event of illness or injury and should be read carefully.

As a condition to my use of the ***Evolve Physical Therapy + Advanced Wellness*** weight/exercise room, I agree to indicate in the space provided below any health problems or physical impairments which would affect my ability to participate in exercise programs or otherwise engage in exercises at ***Evolve Physical Therapy + Advanced Wellness.***

I hereby release ***Evolve Physical Therapy + Advanced Wellness*** (the owners of the facility), its agents, directors and employees and its and their successors and assigns from any and all claims and demands of whatever nature for any and all losses, expenses, damages and costs suffered or incurred by an account of, or in any way growing out of illness or injuries which I may suffer or sustain by virtue of my use of the ***Evolve Physical Therapy + Advanced Wellness*** weight/exercise room except for illness or injury suffered or sustained by me as a direct result of the gross negligence or willful misconduct of ***Evolve Physical Therapy + Advanced Wellness*** or its owners, guests, directors and employees. No employee or agent of ***Evolve Physical Therapy + Advanced Wellness*** has the authority to alter in any way the provisions stated herein.

By signing this waiver, Client/Member/Guest acknowledges that Client/Member/Guest or Responsible Party is of legal age, has received a completed copy of this waiver and has read the foregoing and understand it and any questions you may have asked regarding the use of the ***Evolve Physical Therapy + Advanced Wellness*** weight/exercise room have been answered to your satisfaction.

Type text here
_____
Name Printed

_____ _____
Member/Guest Signature **Date**

If Client/Member/Guest is under 18 years old, Responsible Party's Signature:

_____ _____
Responsible Party Signature **Date**

Statement of Member/Guest as to physical impairment(s)
Does the member/guest have any physical impairment(s) or illness which could affect his/her participation in an exercise program(s) at ***Evolve Physical Therapy + Advanced Wellness***?

Yes_____ No_____

If yes, please explain_____

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PATIENT INFORMATION

☐ New Patient ☐ Returning Patient ☐ Current Patient Type text here

Referred By	Physician's Name	Date

Patient Name (Last, First, Initial)		Email Address	
Home Address		City	State / Zip
Home Phone	Work Phone	Ext.	Cell Phone
Sex M F	Last 4 of SS # XXX-XX-	Birthdate	

Primary Insurance	Name of Insured	Relationship
Secondary Insurance	Name of Insured	Relationship

Check the appropriate box:

☐ Work Related Injury ☐ Auto Accident ☐ Reoccuring Injury ☐ Other

☐ Private Injury ☐ Student Athletic Injury ☐ On-campus Injury ☐ Surgery

Patient Employer	City
Is Patient a Student? Y N	School Name

In case of emergency please notify:	Phone	Relationship
Address	City / State / Zip	
If patient is a minor, name of responsible person	Phone of responsible person	

_____ INITIAL

I hereby authorize Evolve Physical Therapy + Advanced Wellness to release any information acquired in the course of my evaluation or treatment for billing purposes.

_____ INITIAL

I hereby authorize Evolve Physical Therapy + Advanced Wellness to release any information regarding my medical condition to the attending or referring medical practitioner.

_____ INITIAL

I direct that payments be made directly to Evolve Physical Therapy + Advanced Wellness. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to this office.

Signature of Patient or Responsible Party	Date

Go Green This original will be kept in your chart. A copy of this form is available upon request

Patient Intake Questionnaire

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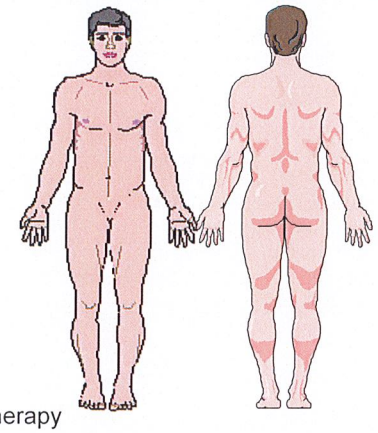
Date: _____

Patient's Name: _____ Age: _____ Sex: _____

1. What is the complaint that brought you here? _____
2. When did this complaint begin, or recently become worse? Approximate Date: _____
3. What caused this complaint? _____
4. What makes this complaint better? _____
5. What symptoms are you experiencing with this complaint?
   - ☐ Swelling
   - ☐ Loss of balance or coordination
   - ☐ Loss of motion
   - ☐ Numbness
   - ☐ Pain: Draw pain areas on body diagrams ->
   - ☐ Weakness
   - ☐ Tingling
   - ☐ Other (Specify)



6. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent
7. How much pain are you experiencing?
   ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
8. What tests have you had for this complaint?
   ☐ X-ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan
9. What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy
   ☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine-(Specify): _____

About your general health:

10. Please check all medical conditions that you have, or have had.
    - ☐ Arthritis ☐ Cardiac History ☐ Stomach Disorder ☐ Headaches
    - ☐ Cancer ☐ High Blood Pressure ☐ Anxiety ☐ Dizziness
    - ☐ Diabetes ☐ Lung Disease ☐ Depression ☐ Metal Implants
    - ☐ Stroke/Seizure ☐ Thyroid Problems ☐ Panic Attacks ☐ Pregnant
11. Please check all of the following items that currently apply to you.
    ☐ Hearing Problem ☐ Visual Problems ☐ Recent weight loss ☐ Bowel or bladder control ☐ Smoker
12. Please list surgeries: _____
13. Please list allergies: _____
14. Please list medications you are currently taking: _____

_____

15. What goals do you want to achieve through your treatment at Evolve Physical Therapy + Advanced Wellness? _____

_____

16. How many fruits and vegetable do you eat per day? (1= your fist size): _____
17. Which of the following areas are you interested in improving? (Check all that apply)
    - ☐ Energy ☐ Skin ☐ Decrease Inflammation ☐ Immune System
    - ☐ Digestion ☐ Heart Health ☐ Mouth and Gum Health ☐ Sleep

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