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** may 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.

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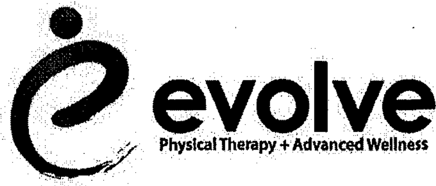

NOTICE OF PATIENT INFORMATION PRACTICES

****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 authorization before 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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PATIENT INFORMATION

☐ New Patient ☐ Old Patient Returning

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	SS# - -	Birthdate	Drivers License #		

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 ☐ Full Time ☐ Part Time	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			

________ 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.
INITIAL

Signature of Patient or Responsible Party	Date

Your Insurance CANNOT be billed without a current prescription from your doctor

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

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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 cannot 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 24-hour notice to change or cancel a scheduled appointment. If you fail to show or cancel your appointment without a 24-hour notice you will be charged $60.00. Payment is due before your next appointment. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier.

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 your 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 the services you receive. We may request your direct involvement in following up on 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 expedites payment for your services.

5. "Cash Pay" services will not be billed to insurance. 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: F3, Fit 2 Live, Yoga
   - 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 be collected or overpayments will be refunded.

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

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 ____________________

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

Patient Intake Questionnaire

Date: ____________________

Patient's Name: ______________________________

Age: __________ Sex: __________

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About your current complaint:

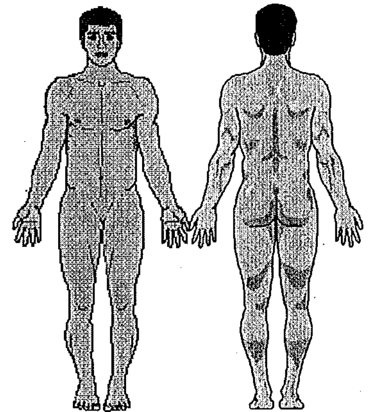
1. What is the complaint that brought you here? ______________________________
2. When did this complaint begin, or recently become worse? Approximate Date: ______________________
3. What caused this complaint? ______________________________
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: ☐ Yes ☐ No

   If "Yes", what activities? ______________________________
5. What makes this complaint better? ______________________________
6. Does this complaint affect your comfort, mood, or ability to sleep? ☐ Yes ☐ No
7. 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)



8. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent
9. How much pain are you experiencing?

   ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
10. What tests have you had for this complaint?

    ☐ X-ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan
11. What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy

    ☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine-(Specify): ______________________
12. Is this complaint work related? ☐ Yes ☐ No

    If "Yes", your employer's name: ______________________ Your Occupation: ______________________

    Work Status: ☐ Full Time ☐ Part Time ☐ Working ☐ Medical Restrictions ☐ Medical Leave Last Date Worked: __________
13. Is this complaint auto related? ☐ Yes ☐ No

About your general health:

14. Please check all medical conditions that you have, or have had.

    ☐ Arthritis ☐ Heart Disease ☐ Stomach Disorder ☐ Headaches ☐ Pace Maker

    ☐ Cancer ☐ High Blood Pressure ☐ Anxiety ☐ Dizziness ☐ Other: __________

    ☐ Diabetes ☐ Lung Disease ☐ Depression ☐ Metal Implants

    ☐ Stroke/Seizure ☐ Thyroid Problems ☐ Panic Attacks ☐ Morning Stiffness
15. Please check all of the following items that currently apply to you.

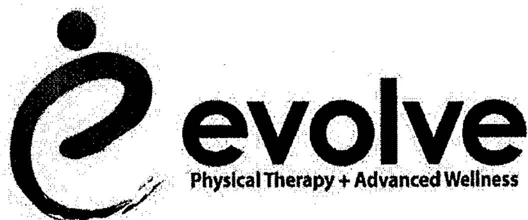
    ☐ Hearing Problem ☐ Visual Problems ☐ Learning Problems

    ☐ Pregnant ☐ Bowel or bladder control ☐ Smoker ☐ Recent weight loss
16. Please list surgeries: ______________________________
17. Please list allergies: ______________________________
18. Please list medications you are currently taking: ______________________________

    ____
19. What goals do you want to achieve through your treatment at Evolve Physical Therapy + Advanced Wellness? ______________________

    ____

Please use the back of page for additional writing space as needed.



PATIENT INFORMATION CONSENT FORM

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

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

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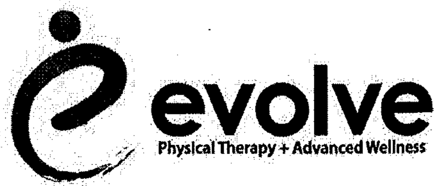


Waiver in Connection with use by Members and Guests of Evolve Physical Therapy + Advanced Wellness

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.

____
Name Printed

____________________________________ ______________________
Member/Guest Signature **Date**

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

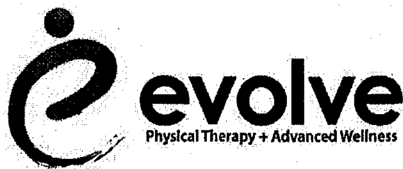
____________________________________ ______________________
Responsible Party Signature **Date**

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____

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



ADVANCE BENEFICIARY NOTICE (ABN)

Name______________________ **Date**________ **Medicare Number**______________

Note: You need to make a choice about receiving these health care items or services.

As of January 1, 2012, Medicare instated a $1880.00 cap for outpatient physical therapy benefits. We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for the following items or services because: Medicare believes there is not enough substantial evidence to prove these items or services advantageous to the patient's recovery process.

1. Iontophoresis
2. Dexamethazone
3. Massage Therapy

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decisions about your options, you should:

1. Read this entire notice carefully.
2. Ask us to explain, if you do not understand why Medicare probably will not pay.
3. Ask us how much these items or services will cost you (Estimated Cost $_____), in case you have to pay for them yourself or through other insurance.

Please choose one option. Check one box. Sign and date your choice.

□ **Option 1: YES**, I want to receive these items or services
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

□ **Option 2: NO**, I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare will not pay.

____ ________________

Signature of Patient or Person acting on Patient's Behalf **Date**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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evolve
Physical Therapy + Advanced Wellness

Medication List

Patient's Name________________________________ Date of Service__________

Please list current medications (including prescription, over-the-counter, herbals, vitamin/ mineral/dietary [nutritional] supplements) including drug name, dosage, frequency and route of administration.

Drug Name	Dosage	Frequency	Route

____
Therapist's Signature

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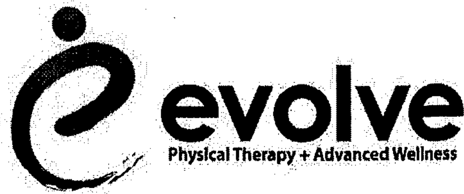

PATIENT HISTORY

Patient Name: ____________________________

Clinical Record #: ____________________

Mark an "X" next to any of the following which you currently have or have had in the past:
_____ Circulatory Disorder _____Heart Disease _____Heart Attack
_____ Surgery _____Sensitivity to Heat _____Sensitivity to cold
_____ High blood pressure _____Hernia _____Allergies

If you marked an "X" next to any of the above, please explain and give appropriate dates:
____
____
____

Are you presently taking and medication on a regular basis? _____Yes _____No

If yes, please list them and explain for what reason: ______________________

Mark an "X" next to any of the following with which you need assistance:
_____Transportation _____Meals _____Domestic Chores
_____Shopping/Errands _____Personal Care _____Other

Mark an "X" next to any of the following which your illness/disability has caused:
____Financial Problems ____Family Problems ____Emotional Problems____Other

Please explain____
What form of treatment have you previously received?______________________

Are you prevented from doing anything you use do?________________________ What are your goals for treatment?___________________________________

Date____________ Patient Signature______________________________

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