PATIENT INFORMATION

Patient Name: ____________________ Phone #________________Cell # __________________

Date of Birth:_______ M/F Last 4 of Social Security #:_________ Driver's License # ________

Address: ______________________________ City, State, Zip __________________________

Email Address: ____

Employer: _________________ Occupation: ________________ Work Phone # ___________

Emergency Contact: ________________Phone #_______________Relationship: _____________

PHYSICIAN INFORMATION

Primary Care Physician: ______________________Phone:__________Location: _______________

Referring Physician:______________________Phone:_____________Location:________________

INSURANCE (if card is not available)

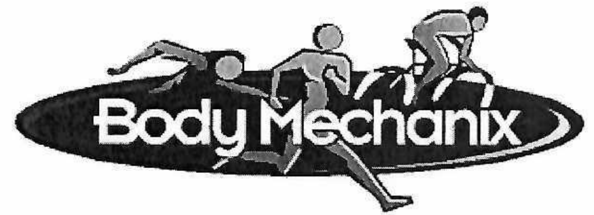
Primary Insurance Co. ___________________ Policy/Member # ____________________________

Secondary Insurance Co. _________________ Policy/Member # ____________________________

Release/Payment Authorization

I authorize payment of medical benefits to Body Mechanix Physical Therapy on the itemized bill. I authorize Body Mechanix Physical Therapy to release medical and billing information required to process claims for payment or as necessary for care in the course of my treatment.

Patient signature: ___________________________________ Date:___________________



Patient/Responsible Party Name: ______________________________

ASSIGNMENT OF BENEFITS

_______**(Initial)** I hereby authorize, Body Mechanix Physical Therapy to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Body Mechanix Physical Therapy directly for services rendered.

CANCELLATION/NO SHOW POLICY (SEE PAGE IN BACK)

_______**(Initial)** Patients failing to show at their scheduled appointment time or canceling with less than 24 hours notice will be charged $40. For Patients with Authorizations such as VA, Workers Comp, ect, after 2 cancellations or no shows we will contact your Adjuster or VA representative and Discharge your case. All Charges will be due on your next visit. There will be a service charge of $25 on all returned checks. Please keep page given to you at the back of these forms.

NOTICE OF PRIVACY PRACTICES (In the Back of this Packet)

_______**(Initial)** By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Body Mechanix Physical Therapy, Inc. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.Our "Notice of Privacy Practices" is subject to change.

CONSENT TO TREATMENT

_______**(Initial)** I give consent for Body Mechanix Physical Therapy to treat any condition within the scope of practice defined by the by American Physical Therapy Association Practice Act for me, my child, or my legal ward.

PAYMENT FOR SERVICES

_______**(Initial) Patients are responsible** for payment of their account regardless of insurance coverage. If the patient is a minor, the parent or guardian is financially responsible. **As a courtesy we will bill your insurance company** unless you make other arrangements with us prior to your treatment. **Deductibles, Co-pays and coinsurances** are due and payable at the time of each visit. If you owe payment **after treatment** you will receive a billing statement explaining your financial obligation. If your insurance plan has **coverage limits** ultimately it is your responsibility to know and stay within the limits of your insurance coverage, however as a courtesy our office will work with you to prevent you from exceeding your benefits. **If you exceed your benefits or your insurance company denies payment for any reason you will be financially responsible to pay all amounts due. You should contact your insurance company(ies) and find out how your individual plan covers physical therapy.**

WORK RELATED INJURIES

_______**(Initial)** If you have a work related injury we will try to obtain authorization from the carrier. We do not accept liens so your injury must be accepted by your Workers Compensation carrier. Please supply us with the following information: (1) Name and address of your employer at the time of injury (2). Name and phone number of the Workers' Compensation carrier and/or adjuster responsible for claims (3.) Claim number

CASH PATIENTS

_______**(Initial) Payments for cash visits are due at the time of treatment.** If payment is not received at the time of treatment, a service charge of ten percent (10%) will be added to your balance and will be due at or before your next visit. Ten percent (10%) service fee will be added to cash visit payment(s) requiring an invoice.

☐ Check Here to Opt out of marketing communication from our Practice

☐ Check here if you would not like us to use your information for Fundraising Purposes

I have read, understand and agree to the above Policies for Body Mechanix Physical Therapy, Inc.

Signature:______________________________ Date:________________

If you would like to request a copy of the above, please check the box. ☐

MEDICAL HISTORY

Other health problems may affect your treatment. Please check any of the following that apply to you:

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing even with hearing aids
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer

Describe any conditions checked above:____

____

Is this injury due to an auto accident? **Yes / No** Is this injury Workers Comp? **Yes / No**

Date of injury or onset ________________ **Body part(s) injured:**____________________________

Has another Physical Therapist, Chiropractor, Acupuncturist, or other rehabilitation facility treated you for any condition this year? **Yes/No ;** If Yes explain:______________________________

Falls History: Injury as a result of a fall in the past year? __________If yes, date of fall:________________

Two or more falls in the last year? ________If yes, dates of falls:______________________

Surgical History:

Body Region:____________________ Surgery Type:____________________ Date of Surgery:______________

Body Region:____________________ Surgery Type:____________________ Date of Surgery:______________

Body Region:____________________ Surgery Type:____________________ Date of Surgery:______________

Current Medications:

Drug:____________________ Dosage:______________ Reason for taking:__________________________

Drug:____________________ Dosage:______________ Reason for taking:__________________________

Drug:____________________ Dosage:______________ Reason for taking:__________________________

Drug:____________________ Dosage:______________ Reason for taking:__________________________

Printed Patient Name:______________________________________**Date of Birth:**________________

Patient Signature:____**Today's Date:**________________

Sports & Orthopedic Physical Therapy

PATIENT DRESS CODE

In order to make your treatment experience comfortable, safe and productive we require that you wear:

- Crew neck t-shirts with or without sleeves, Tank tops are allowed but please no spaghetti straps
- Comfortable pants: long or short
- Closed toed shoes in the facility

MISSED APPOINTMENT & CANCELLATION POLICY

We require patients give our office **24 hours notice** in the event that an appointment needs to be rescheduled. This allows for other patients to be scheduled into that appointment. If a patient cancels an appointment with less than 24 hours, this will be considered a late cancel appointment. A fee of **$40.00** will be charged to the patient; this fee cannot be billed to the patient's insurance company and will be the patient's direct responsibility. No future appointments can be scheduled without the payment of this fee. If a patient misses multiple appointments due to "no show" or "late cancel," we may require the patient to schedule day of appointments or 1 appointment at a time.

Attn: Work Comp patients/VA Patients: Body Mechanix is required to report any Late Cancellations or No-Shows to Triwest, Workman's Compensation adjusters or Nurse Case Managers. We may discharge any Work Comp or VA Patient that accumulates (2) or more late cancels or No Shows.

Additionally, if a patient is **more than 10 minutes late** without prior notice for a scheduled appointment, we may consider this a missed appointment and the **$40.00 cancellation fee** could be applied (depending on our schedule availability)

If you have any questions regarding any of these policies, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

BODY MECHANIX PHYSICAL THERAPY, INC

Notice of Privacy Practices

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this Notice.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures; How the Practice May Use or Disclose Your Health Information

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of diagnostic tests, evaluations, notes, MD orders and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of BODY MECHANIX PHYSICAL THERAPY, INC. For example, information on the services you received may be used to support budgeting and financial reporting, decisions, and activities to evaluate and promote quality.

Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office.

Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health Reporting: We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult 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. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. We may, and are sometimes required by law, 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 the general public.

Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Other Uses and Disclosures: Coroners: We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group
Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
Appointment reminders &Text/Emails regarding treatment: Your health information may be used by our office staff to contact you about your bill, or to remind you of appointments by phone, text, email or by speaking with you personally or leaving a message with an individual or on a message machine or voicemail. We also may send you reminders via text or email. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting i.e., monthly newsletter via email. We may also send you information describing other health-related products and services we believe may interest you. **Electronic Medical Records**: If you request an electronic copy of electronically maintained records, we must provide access in the electronic format you request. If it is not readily producible it will be provided to you in a readable format, we agree upon i.e., a PDF, HTML, Word or Excel document.
Email Communications: Upon your request we may send you unencrypted emails if we advise you of the risk and you still prefer to receive communication(s) or records via unencrypted email.
Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- **Right to Request Special Privacy Protections**: You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed.
- **Right to receive confidential communications** concerning your medical condition and treatment: You have the right to request that you receive your health information in a specific way or at a specific location
- **Right to Inspect and Copy** You have the right to inspect and copy your health information, with limited exceptions.
- **Right to Amend or Supplement**: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete.
- **Right to Amend or Submit Corrections** to your protected health information
- **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in (treatment), (payment), (health care operations), (notification and communication with family) and (specialized government functions) of the beginning section of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
- **Right to receive a printed copy of this notice**
- **Right to restrict disclosures of protected health information to health plans**: where you have paid out of pocket in full for your healthcare services or items.

BODY MECHANIX PHYSICAL THERAPY Responsibilities

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices: As permitted by Law: We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices 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.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting STEVIE @ BODY MECHANIX PHYSICAL THERAPY. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our Privacy Officer: BODY MECHANIX PHYSICAL THERAPY, INC, 1922 ERRINGER ROAD, SIMI VALLEY CA 93065 ATTN: Stevie Scatoloni or call Directly at 805-584-0001 Extension 3. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

BODY MECHANIX PHYSICAL THERAPY, INC
1922 ERRINGER RD
SIMI VALLEY, CA 93065
ATTN: STEVIE SCATOLONI
OFFICE MANAGER
PHONE: 805 584 0001
This notice is effective on or after 1/1/22

Notice of Privacy Practices Availability: This notice will be posted where registration occurs. All individuals receiving care will be provided a hard copy upon request and asked to acknowledge receipt.