Name: ___________________________ DOB: ____/______/_____ Age: ______ SS#________________

Address: _______________________________________City:____________ State: ______Zip: __________

Home Phone: (____) ______-______Cell Phone: (____) ____-_________ M/F: ____ Date of Injury:______

Email: ____ Height: ____________ Weight: ______lbs.

Marital Status: (circle one) M S W D Other Spouse: ___________________________

How did you hear about In Motion O.C.?_____________________ Occupation: _____________________

Employer's Name:______________________________

Address: ___________________________________City:___________ State: _____ Zip: ______________

Work Phone: (___) ______-_________ Referring Physician: _____________________________________

Emergency Contact: _______________ Phone: (____) ______-________ Relationship: _______________

Do you have a Flex or Health Savings Account? _____________

Present/Past Condition: (circle if applicable)

Condition			Condition		
Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulatory Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/other implant	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N
Dizziness	Y	N	Nervous/Anxiety Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema/COPD/ARDS	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting/Fatigue	Y	N	Planning a pregnancy	Y	N
Neurological Disease	Y	N	Stroke or TIA	Y	N
Headaches	Y	N	Thyroid Problem	Y	N
Hepatitis/AIDS	Y	N	Tuberculosis	Y	N
Fever/chills/sweats	Y	N	Weakness	Y	N
Weight change	Y	N	Night Pain	Y	N
Nausea/vomiting	Y	N	Allergies	Y	N
Gastrointestinal Disease	Y	N	Incontinence	Y	N
Urinary frequency changes	Y	N	Sleep Dysfunction	Y	N
Visual impairment	Y	N	Hearing Impairment	Y	N
Previous Accidents	Y	N	Peripheral Vascular Disease	Y	N
Angina	Y	N	Back Pain	Y	N

If yes was answered to any of the above, please explain: ____

____

Have you had any medical problems or hospitalization in the past year (circle one)? Y N

If "yes" please explain: ____

Surgical History: Procedure: ___________________________________ Date: ________________

Procedure: ___________________________________ Date: ________________

Prescription Medication: ____

Over the Counter Medication: ____

Tobacco Use? Y N How long? _______________

Alcohol? Y N Drinks per Week? __________

Patient Signature: ____ Date: _____________________

Guarantor (if under 18):____ Date: _____________________

Name_________________

Describe condition and areas involved: ____
____

What daily activities have been affected by your condition? ____
____

Circle One:

1. **Do you limit the kind of work or other daily activities as a result of your physical health?** Y N
2. **Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health?** Y N
3. **How much does pain interfere with your normal work (including work outside the home, work around the yard, and housework?** ___Extreme ___Quite a bit ___Mild ___None
4. **How much pain have you had during the past 24 hours?** ___Severe ___Moderate ___Mild ___None
5. **Rate your pain on a scale from 0 to 10.** (0 being no pain) ______
6. **How often did you complete at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to onset of your condition?** ___3 times/week ____1-2 per/week ____None
7. **How many days ago did this condition begin?** __0-7 __8-14 ___15-21 ___22-90 __91-6 months ___More than 6 months
8. **I should not do physical activities which (might) make my pain worse?**
   ____0- Disagree __1 ___2 ___3-Unsure ___4 ___5 ___6-Agree
9. **Have you received treatments elsewhere for this condition before?** Y N
10. **How much pain have you had during the past 24 hours?** ___Severe ___Moderate ___Mild ___None
11. **Are you taking prescription medication for this condition?**
    ___No ___Yes, less than before ___Yes, the same as before ____Yes, more than before

We are interested in knowing how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done the activity, please make your best guess as to which response is most accurate.

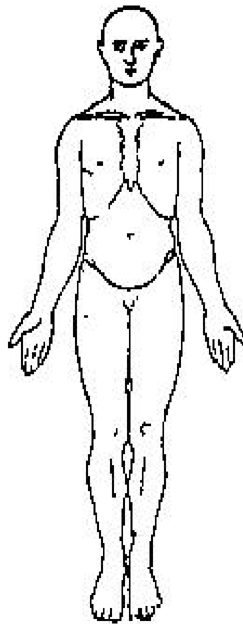
Today, would your health problem limit:	Yes, limited a lot	Yes, limited a bit	No, not limited
Lifting 20 lbs. or more?			
Vigorous activities, such as running more than 5 miles?			
Moderate activities, such as vacuuming?			
Climbing several flights of stairs?			
Climbing one flight of stairs?			
Walking more than 1 mile?			
Walking several blocks?			
Walking 1 block?			
Walking around a room?			
Lifting or carrying items like groceries?			
Gripping or opening a can?			
Handling of small items such as a pen or coins?			
Feeding yourself?			
Getting in and out of bed?			
Bathing or dressing?			
Bending to the floor?			
Kneeling on the floor?			
Control of your bladder?			
Completing your toileting?			

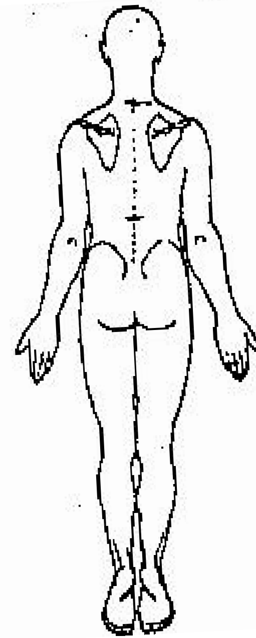
In Motion O.C.
Physical Therapy • Aquatic Therapy • Fitness

Name________________

Where is your pain?

Description of symptoms: Mark the areas on the diagram below where you feel the described sensations. Include all affected areas. Please use symbols on the legend as your indicators.





Burning:	Stabbing:	Numbness:	Pins/Needles:	Ache:
OOO	///	**-- -- --**	/ / /	^^^

Any Additional Information: ____

____

____

____

____

Patient Name: ____

Primary Insurance:

Insurance Company to be Billed: ______________________ **ID #:**_______________________________

Group #: ____________________________ **Name of Primary Insured:** __________________________

Primary's DOB: ____/_______/__________ **Primary's SS#:** ______________________________

Secondary Insurance:

Insurance Company to be Billed: ______________________ **ID #:**_______________________________

Group #: _________________________ **Name of Secondary Insured:** __________________________

Secondary's DOB: ____/_______/________ **Secondary's SS#:** _____________________________

IN MOTION O.C.
FINANCIAL POLICY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ***In Motion O.C.*** to furnish medical care and treatment to: ____, as considered necessary and proper in evaluating or treating his/her physical and mental condition. I hereby instruct and direct my Insurance company to issue check(s) made out and mailed directly to: ***In Motion O.C.,*** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy.

_____
Initial

FINANCIAL POLICY STATEMENT

As a courtesy to you, we may bill your insurance carrier. However, you are responsible for the entire bill for services rendered. If we bill your insurance carrier and we do not receive full payment within 90 days, the balance will be due in full from you. In the event your insurance carrier performs a post treatment review and deems the services not medically necessary, you will be financially responsible for those denied charges. In the event that your insurance company requests a refund of payment made, upon ***In Motion O.C.*** presenting you with notice of the refund made, you will be immediately responsible for the entire amount of money refunded to your insurance company. In the event your employer establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.. In the event that payment is made directly to you for services billed by us, you are obligated to promptly remit the same compensation. If you claim Workers Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

"I understand and agree that if I fail to make any of the payments for which I am responsible, in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees."

_____
Initial

COPAYMENTS

Any Copays and Deductibles are due at the beginning of each visit. *If* your co-pay is a percentage, rather than a fixed dollar amount, there is no way to know exactly what the co-pay will be. In that case, and in the case of a deductible, we will collect an estimated amount on each visit. Any difference will be handled by our billing department after the claim is processed by your insurance company.

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from responsibility for their account balance. ***In Motion O.C.*** *encourages you to contact your Insurance carrier for Physical Therapy benefits under the provisions of your plan.*

Outstanding balances that remain unpaid will ultimately be referred to a collection agency, attorney, or collections will be pursued through other legal means. Additional costs incurred in this process will be added to your financial responsibilities.

_____
Initial

MISSED APPOINTMENTS

We require advance notification for any appointment that needs to be cancelled. Notice of at least a full 24 hours is required in order to allow us time to fill the missed appointment slot. If you fail to give us adequate notice, or if you "no-show" for your appointment, you will be charged a $30 fee.

_____
Initial

TERMS AND LATE FEES

In Motion O.C. provides net thirty (30) payment terms to the patient. This means that the invoice is due within thirty (30) days of being sent. If **In Motion O.C.** does not receive payment within thirty (30) days of the invoice being sent, patient will incur a late fee of 5% per month (60% APR) on the balance that is past due, including previously accrued late fees.

_____
Initial

RETURNED CHECKS

Checks returned due to insufficient funds will be assessed an additional $45 processing fee for the first occurrence. The second time a check is returned due to insufficient funds, there will be a $75 processing fee. Any payment received after that point must be paid by cash, money order, or credit card. You hereby authorize ***In Motion O.C.*** to charge your credit card for returned checks as soon as it receives notice of such occurrence.

_____
Initial

ARBITRATION PROVISION

Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Orange County, California, before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Allocation of Fees and Costs: The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____
Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of ***In Motion O.C.*** health care operations. The Notice of Privacy Practices also describes my rights and ***In Motion O.C.****'s* duties with respect to my protected health information. ***In Motion O.C.*** reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent me via mail, fax, or e-mail, or by asking for a copy at my next visit at the clinic. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that ***In Motion O.C.*** is not required to agree to the restrictions requested.

_____
Initial

I have read, understand, and agree to all of the above. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

____ ______________________
Patient/Guardian/Responsible Party Date

Dear Patient,

Your therapist may recommend the use of Electrical Stimulation as part of your treatment to reduce pain, swelling and inflammation. The electrodes (pads) used during this treatment are a durable medical good not covered by insurance plans. In order to cover our costs, we must charge each patient a **one time fee of $10.** Please realize that this is for each patient's individual benefit, as this will ensure that you will have quality, sanitary pads that will be used by you and only you during your therapy sessions.

By signing below I agree that, if Electrical Stimulation is used in my therapy at least once, to pay a one time fee of $10.

_________________________________ _______________

Patient Signature Date

17332 Von Karman Ave, Suite 120 • Irvine, CA 92614
P: 949.861.8600 • F: 949.861.8601• info@InMotionPT.net • www.InMotionPT.net

Health Information Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

1. About Protected Health Information "PHI"

In this notice, "we" or "us" refer to In Motion Physical Therapy and our workforce of employees and volunteers. "You" or "your" refers to each of our patients who are entitled a copy of this notice. We will use good faith regarding protecting your privacy, however, it is no guarantee from any and all potential risks.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect health information about you in a manner that we describe here. Certain types of health information may specifically identify you. Because we must protect this health information, we refer to it as "Protected Health Information" or "PHI". In this notice we will tell you about:

- How we will use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

2. Some ways we use or disclose your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it in order for us to get paid for your care. We are allowed to dispense or disclose your PHI for certain activities that we call "health care operations". Health care operations involve the administration and quality assurance activities in our facility. We will give you examples of each of these to help explain them. However, this is NOT a complete list of all uses or disclosures.

<u>Treatment:</u>

We use and disclose your PHI in your course of treatment. For example, if you are in our clinic and one of our employees has a question about your condition, we may communicate with your treating physician regarding your diagnosis and plan of care so that we can provide the optimal course of treatment for you. We may also disclose your PHI for other related types of treatment activities. It may be necessary for us to communicate with your referring physician regarding your evaluation and progress in therapy. This may include an introductory letter from our clinic informing the physician of your injury/injuries, as well as whom your therapist is in case the physician needs to contact them. This may also include evaluations, progress notes, etc. This allows us to keep a line of communication with your physician about your progress and plan of care.

<u>Marketing:</u>

We may contact you to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

<u>Payment:</u>

After we treat you, we will ask your insurer to pay us. We use a billing company to administer our billing for us. We provide our billing company your medical information so that they can provide the required information to your insurance company. We, or our billing company, might input some information in to our computers to send a claim to your insurance company. In this instance, we or our billing company, tell your insurer what type of health problem you had and what we did to treat you. Your insurer may ask us to give them your claim or subscriber number or your insurer may want to review your medical records to be sure your care was necessary.

<u>Special Uses:</u>

We may also use or disclose your PHI for the purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- Remind you that you have an appointment with us for treatment
- To contact you regarding your patient account.

<u>Your Authorization May be Required:</u>

In many cases summarized here, we may use or disclose your PHI either with your consent or as required or permitted by law. In all other cases we must ask for, and you must agree to give, a written authorization that has specific instructions and/or limits on our disclosure of your PHI. If you later change your mind, you may revoke your authorization.

3. Certain Uses and Disclosures of your PHI that are Required or Permitted by Law.

Many laws and regulations apply to us that affect your PHI. These laws and regulations may either require us or permit us to use or disclose your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If you do not verbally object, we may share some of your PHI with a <u>family member or friend</u> who is involved in your care
- We may use your PHI <u>in an emergency</u> when you are not able to express yourself.
- <u>When required by law</u>: for example, when a subpoena is ordered by a court to turn over certain types of your PHI, we must do so.
- <u>For public health activities</u> such as reporting a communicable disease or reporting an adverse drug reaction to the Food and Drug Administration (FDA).
- To report <u>abuse, neglect, or domestic violence</u>, as required by law.
- <u>To government regulators or its agents</u> to determine whether we comply with all applicable rules and regulations.
- When <u>properly requested by law enforcement</u>, or for other legal requirements.

- If we believe that disclosing your PHI will avert a potential health hazard or threat to public safety, such as an imminent crime against another person.
- If you are in the armed forces, and it is deemed necessary by appropriate military personnel
- If your workers' compensation claims carrier requires carious PHI information.

4. Certain Requirements We must Follow:
Several state laws may apply to your PHI that set stricter standards then the protections required by federal health privacy regulations.

5. Your Privacy Rights and How to Exercise Them.
You have specific rights under the federally required privacy program, these are summarized here.

Your Right to Request Limited Use or Disclosure
You have the right to request that we do not use or disclose your PHI in a particular way. However, we are NOT required to abide by your request. If we do agree with your request, we must abide by the agreement
Your Right to Confidential Communication
You have the right to receive confidential communication from us at the location you provide. We require that you make your request in writing, providing us with the other address and explain to us if the request will interfere with your care.
Your Right to Revoke Your Consent or Authorization
If you have granted us your consent or authorization to use or disclose your PHI, you may revoke the consent or authorization in writing. However, if we have relied on your consent or authorization we may use or disclose your PHI to that extent.
Your Right to Inspect and Copy
You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause harm, but we must explain why and provide you with someone to contact about our decision who will explain how and when to get a review of our refusal.
Your Rights to Amend You PHI
If you disagree with what your PHI in our records say about you, you have the right to request in writing that we amend your PHI, when it is in a record that we have created or maintained for our purposes. We are not required to respond to your request if the records in question are not our records. You then have the right to submit a written statement as to why you disagree. We may then prepare a counterstatement, both of which will become a part of our record about you.
Your right to Know Who Else Sees Your PHI
You have the right to request an accounting of certain disclosures that we have made of your PHI over the past six years. We do not have to account for all disclosures including those pertaining to treatment, payment, and health care operations as described above. There is no charge for an annual accounting, but there may be a charge for additional accounting. You have the right to withdraw that request at any time.
Your rights To Complain
If you believe your privacy rights have been violated, you have the right to make a complaint to us, or to the Secretary of Health and Human Services. We will not retaliate against you if you make a complaint against us. To file a complaint, you must submit it in writing to the contact listed in section 7. below. You should provide us with a reasonable amount of detail to enable us to perform a proper investigation.

6. Some of Our Privacy Obligations and How We Perform Them.
We are required to comply with the federal health information privacy regulations. These rules require us to protect your PHI. These rules require us to give you notice of our privacy practices. This document is our notice. If you did not get a paper copy of this notice, you may have one. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice or our privacy practices as permitted by law. If we change out notice of privacy practices, we will provide a revised notice when you next receive treatment from us.

7. Contact Information
In Motion O.C.
Attention Privacy Officer
17332 Von Karman Avenue, Suite 120
Irvine, CA 92614

8. Effective Date
This notice takes effect May 1, 2003