New Patient Paperwork

Welcome to Evolution Physical Therapy! Thank you for choosing us to assist you in achieving your goals. We take pride in being the premier sports and orthopedic physical therapy company in Los Angeles and we are confident you will experience great outcomes while having fun doing it!

At Evolution Physical Therapy, our mission is to help all of our patients and clients perform at their highest potential. Our mission is to completely re-define the profession of physical therapy to provide the community with exceptional rehabilitation services, fitness and performance training, prevention and wellness. Our Doctor of Physical Therapy have the best skills, are equipped with the most state-of-the-art equipment, and have an unparalleled drive to help you get better.

This packet is meant to make your first visit to Evolution as seamless as possible. Please arrive 15 minutes early before your first session to complete any necessary paperwork. This can be expedited by completing the paperwork in this packet. Your session will last approximately 1 hour.

Remember to bring the following items with you:

- Driver's license or identification card

- PT Rx if you have visited an MD

- Insurance card

- Comfortable clothing that allows your doctor to assess your injured body part and allows you to move!

PLEASE NOTE - We strictly enforce a 24 hour-notice cancellation policy

It is the responsibility of each patient to verify his/her physical therapy benefits with their insurance companies prior to initiating care. As a patient courtesy, we will do our best to confirm coverage with each patient's insurance plan, but that information is not a guarantee of benefits.

***Parking in Los Angeles is always a challenge, but we have designated areas for you to park at our facilities.**

Evolution Physical Therapy NEW PATIENT FORM

PRINT CLEARLY

Legal Name (First)________________________(Last) __________________________(M.I.) __________

Name Used/Preferred Pronoun _______________________________ *We will make sure to only use your "Name used" and listed pronouns in our facility.

Home Address____

City____State__________Zip__________________________

Cell Phone________________________Work Phone_______________________Other Phone______________________

Social Security__________________ Birth Date______________ Age__________

Drivers License #________________________________Email Address____

Legal Sex M / F *While Evolution PT recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know.

What is your gender identity?

☐ Male
☐ Female
☐ Transgender man / Transman
☐ Transgender woman / Transwoman
☐ Genderqueer / Gender nonconforming
Additional identity (fill in) ________________
☐ Decline to state

What sex were you assigned at birth?

☐ Male
☐ Female
☐ Decline to state

Primary Insurance Subscriber (If different from above): (First)_________________(Last) ____________________

Social Security #_____________________________Date of Birth _______________________________

Status Married / Single / Divorced / Separated / Widowed

Emergency Contact____Telephone_______________________________

Referring Physician____Telephone ______________________________

Address____

Who may we thank for your referral other than your Doctor?____

Employer____**Employment** Full / Part-time / Not Working / Retired

Address____Phone__________________________

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_________________________Injury Date _____________________

Lawyer Involved Yes / No Attorney name ____

Address____Telephone # _______________________

Patient Signature:____**Date:**

Evolution Physical Therapy **MEDICAL HISTORY**

Patient Name____ Age________

Type of Injury / Condition ____

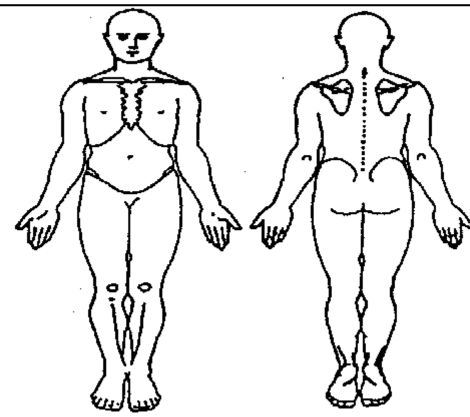
Onset / Injury Date________________________________

Type of Surgery & Date ________________________________

Next Doctor's Appointment? ________________________________

Describe previous treatment for this condition________________

____



Please mark the area(s) of

Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

X-Ray
MRI
CT Scan
Doppler
Ultrasound

Have you recently noted:

Weight Loss /Gain
Weakness
Pregnant / IUD
Pain At Night
Nausea / Vomiting
Fever / Chills / Sweats
Headaches
Cramps In Legs When Walking
Fatigue
Numbness / Tingling
Change In Vision Or Hearing
Insomnia

Do you have now or have you ever had any of the following?

Surgeries
Sprains / Strains
Heart Problems
Circulation Problems / Clots
Easy Bruising / Bleeding
Indigestion / Heartburn
Loss of Consciousness
Diabetes
Cancer
Asthma / Breathing Problems
Leg / Ankle Swelling
Fainting
Fractures
Blood Pressure Problems
Motor Vehicle Accident
Lung Disease
Urinary Problems / Infections
Allergies / Skin Sensitivity

Any previous injury that may affect current care ________________________________

Explain & give approximate dates for any items indicated above________________________________

____

Are you currently taking medications? Yes / No Name or Type of Medication ________________________

____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ________________________

Rate your pain (1=minimal 10=severe): At it's <u>worst</u>: 1 2 3 4 5 6 7 8 9 10 / At it's <u>best</u>: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?________________________________

____

What are your physical or fitness goals: ________________________________

____

Is there anything else you would like to include or ask your physical therapist? ________________________

____

X____
Patient or Personal Representative Signature

X____________________
Date

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required by Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.
For Law Enforcement: We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. **Printed copies of your records will incur a clerical cost of $15.00 plus .25 per page.** If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information, we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. *We are not required to agree to your request.* **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

X____
Patient or Personal Representative Signature

X_________________________
Date

Evolution Physical Therapy

OFFICE POLICY

- **CONSENT FOR CARE & TREATMENT:** Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for Evolution Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.
- **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Evolution Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.
- **WORKERS' COMPENSATION CLAIMS:** 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.
- **CANCELLATION & NO-SHOW POLICY:** We require at least **24 HOURS** notice in the event of a cancellation. Cancellations under 24 hours are considered no shows/late cancels. The charge for cancellation without proper notice is **$75.00** for all services Evolution Physical Therapy offers. This charge will **not** be covered by insurance and must be paid by you **PRIOR** to receiving additional treatment. _______ **(Initials)**
- **SOCIAL MEDIA DISCLOSURE:** I understand that while in Evolution Physical Therapy facilities I may be a background to a subject in platforms. If I am to be the subject, verbal consent will be given in order to produce content.
- **FINANCIAL POLICY:** We bill your personal insurance carrier solely as a courtesy to you. You are responsible for knowing your insurance benefits. We require that arrangements for payment of your estimated share be made today when services are rendered. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. **Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. In the event that your continued treatment with us exceeds the coverage of your insurance policy, you will be responsible for the full cash payment of services rendered.** We will do everything possible in order to obtain additional visits necessary once insurance coverage ceases (including steps necessary to appeal a denial); however, this does not guarantee that your insurance will accept the request to authorize additional visits. **You are also responsible for keeping track of visits covered in your policy.**

  If your insurance authorizes a request for additional visits beyond the initial visits covered in your policy, there will be no change from your financial responsibility outlined in your original policy.

PATIENT RESPONSIBILITY	OTHER
Co-Pay $______________/visit Co-Insurance__________% Deductible $______________/year ($__________/MET)	Insurance visits allowed: _____________________

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient Name:____

X____ **X**____________________

Patient/Guardian/Responsible Party Signature **Date**

____

Clinic Representative **Date**

IF PATIENT IS A MINOR> PARENTAL CONSENT FOR TREATMENT OF A MINOR**:** As parent and/or legal guardian, I authorize **Evolution Physical Therapy, Inc** to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature____________________________________ **Date**_______________