BEVERLY HILLS CENTER FOR PHYSICAL THERAPY

REFERRED BY: ______________________________

Today's Date: ______________________________

For Office Use Only

PI IN PI/IN WC OTHER

ACCT. No.: ______________

PATIENT INFORMATION:

Name: ____ Sex: ____ Birth date: __/__/__

Last First Initial

Address: _________________________ City: ____________ State: ___ Zip: ________

Home Phone: ( ) ___ - __________ SS#: ___-__-_____ ID/DL#: ____________

EMPLOYER:

Company: _________________________ Occupation: _____________________________

Address: ____________________ City: ____________ State: ___ Zip: ___________

Work Phone: ( ) _____________________________

REFERRING PHYSICIAN: ______________________________

Address: _________________________ City: ____________ State: ___ Zip: _________

Phone: ( ) ____ - ____________________

CONTACT PERSON: (In case of emergency) Relationship: ______________________

Name: ____ Phone: ( ) ___ - ______________

Address: ________________________ City: _______________________ Zip: ________

Employment Injury: ☐ Yes ☐ No If Yes, Date of Injury: _________________________

Other Accident: ☐ Yes ☐ No If Yes, Date of Injury: _________________________

Auto Accident: ☐ Yes ☐ No If Yes, Date of Injury: _________________________

- Describe the Accident: ____

  ____

- If Auto Accident, were you:

  ☐Driver ☐Front Passenger ☐Right Rear ☐Left Rear

ATTORNEY INFORMATION:

Name: ____________________________________ Phone: ( ) ___ - _______________

Address: _________________________________ City: _______________ Zip: ________

INSURANCE INFORMATION:

Subscriber's Name: ____

Insurance Co.: ____

Policy No.: ____

Insurance Address: ____

Claim No.: ____

Beverly Hills Center for Physical Therapy
Confidential Medical Questionnaire

Patient Name: ______________________

1) What medications are you presently taking? ______________________________
2) Do you have any of the following conditions?

Heart Disorder	Pacemaker	Diabetes	High Blood Pressure
Cancer	Metal Implants	Kidney Disorder	Respiratory Disorder
Headaches	Vision Disorder	Alcohol/Drug	Incontinence
Arthritis	Hearing Disorder	Depression	Allergies

3) Present condition began when? ______________________________

Please Circle

4) Have you had surgery for this condition?	Yes	No
5) Previous treatment for this condition?	Yes	No
6) Have you had this condition previously?	Yes	No
7) Physical therapy or chiropractic care?	Yes	No
8) Symptoms came on?	Gradually	Suddenly
9) Are your symptoms?	Constant	Intermittent

10) Diagnostic Tests Done? X-rays MRI CT Scan NVC Test Other

11) Signs and Symptoms? Dizziness Weakness Numbing Pain Tingling Burning Headache

12) What decreases your symptoms? ______________________
13) What increases your symptoms? ______________________
14) When do you feel better? ______________________
15) When do you feel worse? ______________________
16) Daily activities affected by this condition? Sitting Standing Stairs Walking Sleeping Driving Lifting Reaching Employment Writing Eating Washing Bathing Sports

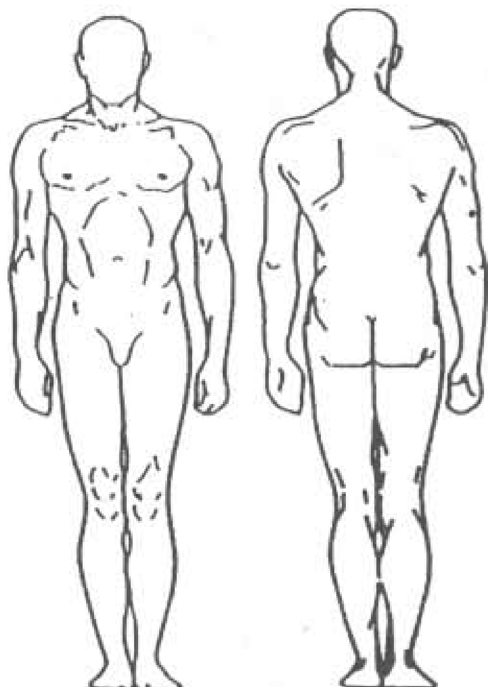
17) What are your goals for physical therapy? ______________________

Pain/Discomfort Scale

Circle the number that indicates pain
(**0** = no pain at all;
10 = need to call 911/emergency pain)

1) Today? 1 2 3 4 5 6 7 8 9 10
2) Worst? 1 2 3 4 5 6 7 8 9 10
3) Least? 1 2 3 4 5 6 7 8 9 10

Body Chart



Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Beverly Hills Center's Notice of Information Practices. I understand that Beverly Hills Center 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 ABC PT/OT 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 Beverly Hills Center's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____

Patient Name

____

Signature

____

Date

I also authorize Beverly Hills Center to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

____

Patient Name

____

Signature

____

Date

AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Patient's Name ______________________________

Insured's Name ______________________________

Social Security No. ______________________________

Policy No. or Claim No. ______________________________

Insurance Company ______________________________

Address ______________________________

____

City State Zip Code

Telephone No. ______________________________

Pay Medical Provider:

BEVERLY HILLS CENTER FOR
PHYSICAL THERAPY AND
REHABILITATION, INC.
9033 WILSHIRE BLVD., SUITE 409
BEVERLY HILLS, CA 90211

1. I authorize the RELEASE OF ANY INFORMATION concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy or Social Security Act.

2. In consideration of the above-named medical provider's rendering of treatment to me without immediate compensation therefore I authorize and IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT of the above named medical provider's bill for treatment rendered to me out of the proceeds of any judgment or settlement in my case and, furthermore, from any insurance company providing coverage to me for such expenses.

3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment, I understand, authorize, and agree that no payments due me under said contract of insurance shall be made to me for any other medical expenses incurred until the above medical provider's BILL FOR MY TREATMENT IS FIRST PAID IN FULL.

4. I give assignment and lien in any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

5 In the event any insurance company obligated by contractural agreement to make payment to me or to the physician refuses to make such payment upon demand, I hereby IRREVOCABLY ASSIGN AND TRANSFER to the medical provider any CAUSE OF ACTION that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in his name and further to compromise, settle, or otherwise resolve said claim.

6. I waive the STATUTE OF LIMITATIONS regarding my provider right to recover.

7. I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.

8. I, hereby appoint the above named medical provider and any of their duly authorized agents and employees, to endorse any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.

NOTICE TO INSURANCE COMPANY OF ASSIGMENT

You are instructed to PAY DIRECTLY TO THE above named medical provider at his office for all professional services rendered to me by his office.
This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim.
Any sum of money paid under this assignment shall be credited to my account.

Patient's signature: ______________________________

Insured's signature: ______________________________
(if different or required)

Beverly Hills Center for Physical Therapy & Rehabilitation, Inc.

NOTICE OF PATIENT INFORMATION PRACTICES

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

BEVERLY HILLS CENTER FOR PHYSICAL THERAPY'S LEGAL DUTY

Beverly Hills Center 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

Beverly Hills Center 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, Beverly Hills Center for Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Beverly Hills Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Beverly Hills Center'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.

Beverly Hills Center 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 an updated 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 not 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. Beverly Hills Center 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 Beverly Hills Center may have violated your privacy rights 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 below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Beverly Hills Center's health information practices or if you have a complaint, please contact the following person:

Beverly Hills Center for Physical Therapy and Rehabilitation, Inc.
9033 Wilshire Blvd., Suite 409, Beverly Hills, CA 90211
Practice Address, Practice City, Practice State Practice Zip
Telephone: 310/278-0204 Fax: 310/278-0171

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

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

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 –**

Items or Services:

If you are receiving any type of HOME HEALTH CARE - MEDICARE will not pay for your Physical Therapy Treatments at this office, and you will, therefore, be responsible for payment to us.

Because:

HOME HEALTH should provide you with Physical Therapy services.

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 a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- 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 & 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 and 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.

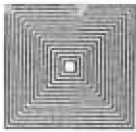
☐ **Option 2. NO. I have decided not to receive these items or services.**

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 won't pay.

Date **Signature of patient or person acting on patient's behalf**

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.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)



Beverly Hills Center for
PHYSICAL THERAPY and
REHABILITATION, INC.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_______________________ Relationship:_______________

Name:_______________________ Relationship:_______________

Name:_______________________ Relationship:_______________

Name:_______________________ Relationship:_______________

____
Patient Name

____
Patient Signature

____
Date

9033 Wilshire Boulevard, Suite 409 • Beverly Hills, California 90211 • (310) 278-0204 • Fax (310) 278-0171

BEVERLY HILLS CENTER FOR PHYSICAL THERAPY
AND REHABILITATION, INC.
9033 WILSHIRE BLVD., SUITE 409
BEVERLY HILLS, CA 90211

TO ALL MEDICARE PATIENTS

We will do everything possible to ensure payment is made by Medicare for your treatment. In the event Medicare fails to pay all or a portion of the bill then you will remain responsible for payment.

Thank you.

BHCPT & REHAB, INC.

x______________________________________
Patient Signature