

# ABA PHYSICAL THERAPY ASSOCIATES

Name: \_\_\_\_\_ Male  Female

Street Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip AGE: \_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

## INSURANCE INFORMATION

Name of the insured: \_\_\_\_\_ Insured's birth date: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ ID # \_\_\_\_\_

Do you have secondary insurance? No Yes

Auto Injury? No  Yes  Date of Auto Accident: \_\_\_\_\_ State \_\_\_\_\_

## PERMISSIONS

Our primary contact is by phone. May we contact you by email? No  Yes  Email: \_\_\_\_\_

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### INSURANCE INFORMATION RELEASE

*I hereby authorize ABA Physical Therapy Associates to release to my Insurance company/attorney, any information regarding this illness and/or injury, which is required to process my claim.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

*I hereby assign my insurance benefits to ABA Physical Therapy Associates and agree to be financially responsible for any unpaid services rendered.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

### Cancellation or No Show Policy:

I understand that if I am unable to cancel my scheduled appointment 24 hours in advance, or "No Show," I will be charged a **\$50.00 Cancellation/No Show Fee for a half hour appointment** or a **\$75.00 cancellation/no show fee for an hour appointment.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

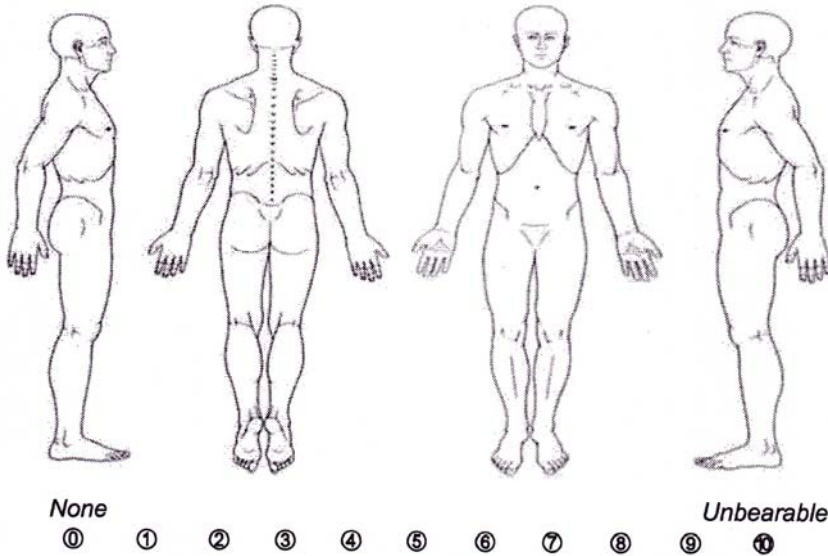
Occupation \_\_\_\_\_ Are you working? YES / NO Hours/week \_\_\_\_\_

1. Describe your symptoms \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

2. Indicate where you have pain or other symptoms. Rate the average intensity of your pain.



3. How often do you experience your symptoms?

- a. constantly (76-100% of the day)
- b. frequently (51-75% of the day)
- c. occasionally (26-50% of the day)
- d. intermittently (0-25% of the day)

4. Describe the nature of your symptoms

- a. sharp
- b. dull ache
- c. numb
- d. shooting
- e. burning
- f. tingling

5. How are your symptoms changing?

- a. getting better
- b. not changing
- c. getting worse

6. In general your overall health is...

- a. excellent
- b. very good
- c. good
- d. fair
- e. poor

7. Who have you seen for your symptoms?

- a. No one
- b. medical doctor
- c. chiropractor
- d. physical therapist
- e. other

What treatment did you receive and when? \_\_\_\_\_

Have you had: X-rays date: \_\_\_\_\_  
MRI date: \_\_\_\_\_

CT scan date: \_\_\_\_\_  
Other date: \_\_\_\_\_

8. Have you had similar symptoms in the past? YES / NO  
symptoms who did you see?

- a. This office
- c. chiropractor

If you received treatment for similar  
b. medical doctor  
d. physical therapist  
e. other

PLEASE SEE OTHER SIDE



## 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.

### *ABA Physical Therapy Associates'* LEGAL DUTY

**ABA Physical Therapy Associates** 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

**ABA Physical Therapy Associates** 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, **ABA Physical Therapy Associates** 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.

**ABA Physical Therapy Associates** may also use or disclose your personal health information without prior authorization for emergencies. We also provide information when required by law.

In any other situation, **ABA Physical Therapy Associates'** 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.

**ABA Physical Therapy Associates** 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. **ABA Physical Therapy Associates** 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 **ABA Physical Therapy Associates** 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 **ABA Physical Therapy Associates'** health information practices or if you have a complaint, please contact the following person:

*ABA Physical Therapy Associates*  
*Marilyn S. Beames*  
*Office Manager*  
Telephone: 650.558.0247    Fax: 650.558.1735

HIPAA PRIVACY NOTICE AND PATIENT INFORMATION CONSENT FORM

I have read and fully understand *ABA Physical Therapy Associates'* Notice of Information Practices. I understand that *ABA Physical Therapy Associates* 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 ABA Physical Therapy Associates 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 *ABA Physical Therapy Associates'* 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 \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

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Please sign the authorization below if you would like to share your medical information with a family member, friend or medical provider other than the referring physician.

**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 \_\_\_\_\_

Patient Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_