TOWER PHYSICAL THERAPY, INC.

Patient Name: _____

Address_____ **City**_____ **Zip Code**_____

Birthdate _____ **Social Security Number** _____ **Sex: M / F**

Primary Phone:_____ **Secondary Phone:** _____
Type: ☐ **Cell** ☐ **Home** ☐ **Other** **Type:** ☐ **Cell** ☐ **Home** ☐ **Other**

Email: (for appointment reminders) _____

Employer_____ **Occupation**_____

Work Phone:_____

Emergency Contact_____ **Phone**_____ **Relation**_____

Insurance Information

Insurance Subscriber's Name (if different):_____ **DOB**_____

Patient's Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

**** OFFICE USE ONLY****

DEDUCTIBLE:_____ **MET:** _____ **COINSURANCE:**_____/_____

VISIT LIMIT: _____ **PRE-CERT REQUIRED:** _____

COPAY: $_____ **per visit**

*** For patients under the age of 18 ONLY ***

I _____ **, hereby grant Tower Physical Therapy, Inc. consent to provide any**
Parent/Guardian
necessary treatment for my child (patient), throughout the duration of treatment without requiring my presence at future appointments.

_____ _____ _____
Parent Date of Birth **Parent Social Security** **Parent Phone No.**

ASSIGNMENT OF BENEFITS

Authorization for treatment is hereby given to Tower Physical Therapy, Inc. I assign them all payments for medical services rendered. I also authorize them to furnish as well as obtain all medical records necessary concerning this injury/illness to or from any doctor/insurance carrier. I have read and understand the benefits above. ***I hereby certify that the above statements are true and correct to the best of my knowledge.***

X_____ _____

Patient or Guardian Signature **Today's Date**

CONTINUE ON BACK

How did this injury occur? _____

_____

	Yes	No	
Is your injury due to auto accident?	[ ]	[ ]	**Date of auto accident:** _____
Was this injury work related?	[ ]	[ ]	**Date of injury:** _____
Did you have surgery?	[ ]	[ ]	**Date of surgery:** _____
Have you seen a Physical Therapist for this condition?	[ ]	[ ]	**If yes, when and how many sessions?** _____
Have you seen a Chiropractor for this condition?	[ ]	[ ]	
Are you taking any medications for this condition?	[ ]	[ ]	

If yes, check boxes that apply: [ ] Pain [ ] Anti-inflammatory [ ] Muscle relaxers

What aggravates your condition? _____

(example: walking, standing, pushing)

What eases your condition? _____

(example: rest, ice, heat)

What does this condition impair you to do? _____

(example: dressing, housework)

Please describe your pain- [ ] Sharp [ ] Dull [ ] Burning [ ] Electrical [ ] Cramping

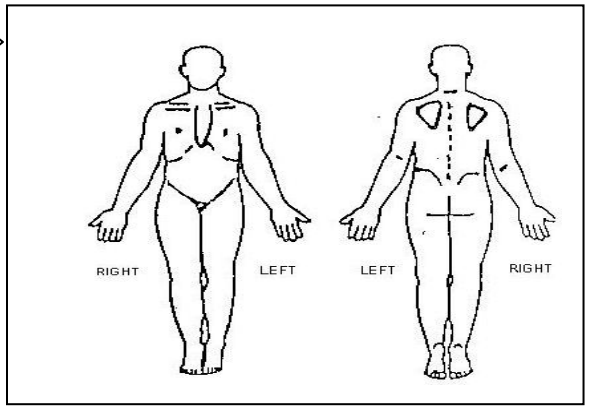
Rate Pain:

At rest? 1 2 3 4 5 6 7 8 9 10

At moderate level of activity? 1 2 3 4 5 6 7 8 9 10

At higher level of activity? 1 2 3 4 5 6 7 8 9 10

Indicate pain location



HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? (Please circle all that apply)

Heart Problems	Diabetes	Cancer	High Blood Pressure	Stroke
Multiple Sclerosis	Asthma	Arthritis	Kidney Disease	Emphysema
Depression	Anemia	Hepatitis	Thyroid Problems	Epilepsy

Other: _____

HOW DID YOU HEAR ABOUT US?

[ ] Doctor Name: _____ **Next doctor appointment:** _____

[ ] Friend [ ] Previous Patient [ ] On-line [ ] Advertisement

TOWER PHYSICAL THERAPY, INC.
1801 Colorado Ave. Suite 260
Turlock, CA 95382

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review this documentation carefully.

Uses and disclosures:

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 laboratory tests 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 the services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations:
Your health information may be used as necessary to support day-to-day activities and management of Tower Physical Therapy, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to promote quality.

Law Enforcement:
Your health information may be disclosed to law enforcement agencies to support government audit and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting:
Your health information may be disclosed to public health agency as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Other Uses and Disclosures Require Your Authorization:
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:
Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

(Continue on back page)

There are certain rights you have under the federal privacy standards listed below:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect your protected health information
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.

Tower Physical Therapy, Inc.

We are required by law to protect the privacy of your health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

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 the receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Grace Chavez / Office Manager
Tower Physical Therapy, Inc
1801 Colorado Ave. Suite 260
Turlock, CA 95382
(209) 216-3360

If you believe that your privacy rights have been violated or for further information concerning our privacy practices, you should call the matter to our attention by sending a letter describing the cause of you concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after April 14, 03

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature _____ Date _____

TOWER PHYSICAL THERAPY, INC.

Private Insurances: Any insurance that does not pertain to a work injury.

Workers Compensation: Work related injury

Please read and sign the following that apply to your health plan.

PRIVATE INSURANCE/MEDI-CARE: Any insurance that does not pertain to a work injury.

If you belong to a preferred provider plan, we will accept as per the contract rate of that health plan. If your health plan has a co-payment, and/or % plan after deductible, you are responsible for that amount. **Co-payments will be collected at the time of your appointment.** For all plans that have a % plan we will bill you for the portioned owed-upon receiving explanation of benefits from your insurance.

If you are not aware of your physical therapy benefits, please let us know and we will acquire them for you, otherwise we will assume you are aware of your benefits.

Patient Signature: _____ Date: _____

WORKERS COMPENSATION:

We will bill the compensation carrier. Signing below lets us know that you indeed did file your injury with your employer and a case was open. Please understand that if determination is made that your claim is not work related you will be responsible for all charges incurred.

Patient Signature: _____ Date: _____