



South Bay Sports & Preventive Medicine Associates, Inc.

Patient Questionnaire

To help us assess the cause of your problem, we ask you to complete this form being seen by a Physical Therapist. Please answer as completely as possible.

First Name: _____ M.I. _____ Last Name: _____

Preferred Name: _____ Age: _____ Ht: _____ Wt: _____

Have you lost or gained (unintentionally) 10lbs or more during the past 6 months? YES NO

Is your doctor aware? YES NO

Physician: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Current Medical Conditions: _____

Long term Medications (prescriptions, over the counter, herbal preparations): _____

Allergies to Medications: _____

Previous Operative/Invasive Procedures: _____

Are you pregnant? YES NO N/A

Do you currently have or have you ever had any of the following problems:

Please circle:

Congestive Heart Disease	YES	NO	Diabetes	YES	NO
High Blood Pressure	YES	NO	Thyroid Disease	YES	NO
Heart Birth Defect	YES	NO	Hepatitis or Liver Disease	YES	NO
Heart Attack	YES	NO	Stomach Ulcers	YES	NO
Angina Pectoris	YES	NO	Venereal Disease	YES	NO
Rheumatic Fever	YES	NO	Osteoporosis	YES	NO
Heart Murmur	YES	NO	AIDS/HIV positive	YES	NO
Collagen or Vascular Disease	YES	NO	Arthritis	YES	NO
Anemia	YES	NO	Hay Fever	YES	NO
Bleeding Problems	YES	NO	Respiratory Disease	YES	NO
Other Blood Disorder	YES	NO	Sinusitis	YES	NO
Stroke	YES	NO	Asthma	YES	NO
Convulsions or Seizures	YES	NO	Tuberculosis	YES	NO
Neurologic Disorder	YES	NO	Emphysema	YES	NO
Nervous or Psychiatric Condition	YES	NO	Bronchitis	YES	NO
Fainting Spells	YES	NO	Glaucoma	YES	NO
Severe Headaches	YES	NO	Cancer	YES	NO
Kidney Disease	YES	NO	Other _____		

Which of these words describe your pain? Please circle all that apply to you.

Sharp Numb Burning Throbbing Variable Worse in the morning Worse at night
Dull Tingling Aching Pins & Needles Constant Worse in the evening

How did your problem start? Please circle all that apply to you.

Work Injury Motor Vehicle Accident Sports Injury Sudden Onset Gradual Onset

Other, please describe: _____



When did this problem start? _____

How did this problem start? _____

Has your pain changed since its original occurrence? If so, how? _____

Are you currently working? YES NO If no, are you not working as a result of this problem? YES NO

Please give your occupation and describe the physical demands of your job: _____

What are your usual (before injury) household/family activities? _____

What are your hobbies? _____

What changes in activity have been necessary because of pain? (Please be specific): _____

What activities increase your pain? _____

What do you do to decrease your pain? _____

What medical tests have you had pertaining to this problem? Where was it performed?

X-rays	YES	NO	_____
MRI	YES	NO	_____
CT Scan	YES	NO	_____
EMG	YES	NO	_____

Have you ever had any other treatments for this problem (ie: previous physical therapy, chiropractic, acupuncture, etc.)? _____

What are your goals for physical therapy? _____

Date of your next Physician appointment: _____

Signature: _____ Date: _____
Patient/Legal Guardian

Reviewed by: _____ Date: _____
Physical/Occupational Therapist



WHERE IS YOUR PAIN NOW?

Mark the areas on the body where you feel the described sensation using the appropriate symbol:

ACHE

AAA

NUMBNESS

OOO

PINS & NEEDLES

BURNING

XXX

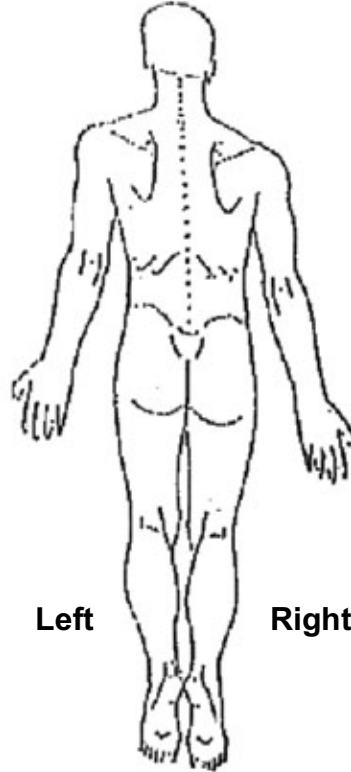
STABBING

///



Right

Left



Left

Right



VISUAL ANALOG SCALE (VAS)

Please mark on the line with an 'X' the degree of pain you have NOW:

No Pain



Worst Pain

Are you now: Better: _____ Worse: _____ Same: _____ since the procedure/injury

Signature: _____ Date: _____

Patient/Legal Guardian



South Bay Sports & Preventive Medicine Associates, Inc.

PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Birthdate: _____ Gender (please circle one): MALE FEMALE OTHER

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status (please circle one): MARRIED SINGLE WIDOWED DIVORCED

Emergency Contact: _____ Phone: _____

Relationship: _____

Patient's Employer: _____ Occupation _____

Employer's Address: _____

City: _____ St: _____ Zip: _____ Work Phone: _____

Best way to reach you (please circle one): HOME WORK CELL

INSURANCE INFORMATION: PRIMARY (Self/Spouse/Parent)

Insurance Name: _____

Insured Name: _____

Birthdate: _____

ID/Policy#: _____

Group/Plan#: _____

Effective Date: _____

INSURANCE INFORMATION: SECONDARY (Self/Spouse/Parent)

Insurance Name: _____

Insured Name: _____

Birthdate: _____

ID/Policy#: _____

Group/Plan#: _____

Effective Date: _____

ASSIGNMENT & RELEASE

Initials

_____ I understand I am financially responsible for co-payments, deductibles, co-insurance percentages and any non-covered services by my health plan at the time of service.

_____ I authorize my provider to release any medical information required by my insurance company for claim processing.

_____ I hereby authorize my insurance benefits to be paid directly to my provider for services rendered.

Signature: _____ Date: _____

Patient/Legal Guardian



South Bay Sports & Preventive Medicine Associates, Inc.

AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by appropriately licensed physical therapists, athletic trainers, physical therapy assistants, and exercise physiologists or other assistances employed by South Bay Sports & Preventive Medicine Associates, Inc. (SBSPMA). Authorization is hereby granted for such treatments and procedures as prescribed by my physician or directed under California "Direct Access."

I understand and acknowledge that as part of my treatment I will be engaging in physical exercises and using exercise equipment and as with all such physical activity there is an inherent risk of injury or complication to my existing condition. I am voluntarily participating in these physical activities and knowingly and freely assume all risks of injury, loss or damage on account of these activities. I understand that results are not guaranteed and that I have the right to discuss the purposes and risks associated with all recommended treatment procedures and activities with my therapist.

I certify that the information provided to SBSPMA by me is correct, and I accept full responsibility for all charges.* I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to SBSPMA, I hereby instruct and direct the SBSPMA to bill me directly for the insurance payments paid to me. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commission charges.

*Patients with valid workers' compensation claims are not responsible for treatment charges.

MEDICAL RECORDS AUTHORIZATION

SBSPMA is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney, or other agency legally involved with my case (proof of relationship will be confirmed).

MEDICARE PATIENTS

I certify that the information provided to SBSPMA by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers an information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize SBSPMA to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

Signature: _____ Date: _____
Patient

Signature: _____ Date: _____
Witness

FOR MINORS

As parent or legal guardian, I have read, understand, and agree with all items stated above and hereby authorize SBSPMA to administer physical medicine treatment as prescribed to

Patient Name

Signature: _____ Date: _____
Patient/Legal Guardian



Patient Financial Responsibility Policy Notice

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office and initial the source of payment indication how your services will be reimbursed.

_____ PRIVATE INSURANCE: Professional services rendered to you (or your dependents) by South Bay Sports & Preventive Medicine Associates, Inc. (SBSPMA) is your sole financial responsibility. SBSPMA will bill your insurance as a courtesy, but you are ultimately responsible for payment for your treatment. You are financially responsible for any and all balances not paid by your insurance (i.e. deductibles, co-pay, coinsurance, denied charges, and fees reduced by usual and customary charges). You are required to pay your reported co-payment on the day of your visit. Any other unpaid balance due will be reflected in your monthly billing statement. Please pay close attention to statement received from your insurance company as they may report balance due prior to receiving a statement from our office. Any unpaid charges on an account for 90 days are subject to collections action. On occasion, an insurance company may send the check for services to you directly. If this occurs, you must reimburse the payment to our office by signing over the check.

_____ WORKER'S COMPENSATION: If you were injured during the course of your employment please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified with your employer and we will bill the worker's compensation carrier directly.

_____ MEDICARE: If Medicare is your primary insurance, we will bill Medicare directly. There may be some expenses Medicare will not cover and therefore you will be expected to sign a waiver and pay at the time of service.

_____ CASH: If you do not have insurance, you will be expected to pay for treatment at the time of service. The cost is \$150.00 for the first initial visit and \$75 per visit thereafter (this is a 50% discounted rate.)

In order to ensure that our patients have access to our provider, South Bay Sports and Preventive Medicine Associates, Inc does enforce a 24 hour cancellation policy and 15 minute late policy. Please initial below indicating that you have read and understand these policies.

_____ Patients will be charged a \$50 no show/same-day cancellation fee if they do not cancel their appointment 24 hours in advance.

_____ Patients who arrive more than 15 minutes late for an appointment will be required to reschedule the appointment. This will count as a no show and a \$50 no show fee will be charged.

Please direct any additional questions you may have to the business office.

It is customary to pay for services at the time they are rendered. For your convenience, payment may be made by cash, check, Visa, MasterCard, or Discover.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO SOUTH BAY SPORTS AND PREVENTIVE MEDICINE ASSOCIATES, INC.

Signature: _____ Date: _____
Patient (or Guardian)

Signature: _____ Date: _____
Witness



South Bay Sports & Preventive Medicine Associates, Inc.

NOTICE OF PRIVACY PRACTICES

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

Our Pledge Regarding Your Health Information

We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you have any questions about the Notice, please contact our Privacy Officer.

This notice will tell you about the ways in which we may use and disclose health information about you, as well as certain obligations we have regarding the use and disclosure of health information. It will also describe your rights regarding your health information.

Our Responsibilities

Our primary responsibility is to safeguard your personal health information. We must give you this notice of our privacy practices and follow the terms of the notice currently in effect.

Changes to this notice: We reserve the right to amend this Notice of Privacy Practices at any time. Until such an amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will post a copy of the current notice in our medical offices and you can pick up a copy at any time at the reception desk.

How We May Use and Disclose Health Information About You

The medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The following categories describe different ways that we use your health information within our medical practice and disclose your health information to persons and entities outside our medical practice. We have not listed every use or disclosure within the categories below but all permitted uses and disclosures will fall within one of the following categories. In addition, there are some uses and disclosures that will require your specific authorization.

Treatment: We use medical information about you to provide medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may also disclose medical information or members of your family or others who can help you when you are sick or injured.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose medical information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information in our quality assurance activities, to review and improve the quality of care we provide. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical review, credentialing, legal services, and audits, involving fraud and abuse detection and compliance programs, as well as business development, planning and management. We may also share your medical information with our "business associates," such as our billing service that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearing house, under California law, all recipients of health care information are prohibited from redisclosing it except as specifically required or permitted by law.

We may also share your information with other health care providers, health care clearinghouses, or health plans that have a relationship with you when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence qualifications, and performance of health care professionals, their training programs, their accreditation, certification, or licensing activities or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders: We may use and disclose medical information to contact you and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign-in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.



Notification and communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death, in the event of disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.

Marketing: We may contact you to give you information about products or services related to your treatment, case management or care coordination, or direct to recommend other treatment or health-related benefits and services that may be of interest to you.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Special Situations that Do Not Require Your Authorization: State or federal law permits the following disclosures of your health information without verbal or written permission from you. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law.

Organ and Tissue Donation: We may release health information to organizations involved in procuring, banking or transplanting organs and tissues,

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic report to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

Averting a Serious Threat to Health or Safety: We may use and disclose health information about you, when necessary, to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Public Health: We may disclose information about you to public health authorities for purposes related to: Preventing or controlling disease injury or disability; reporting child, elder or dependent adult abuse or neglect, reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease of infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or our personal representative promptly unless in our best professional judgement, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may be required to disclose health information about you in the course of the administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes, identifying the victim of a crime if, under certain circumstances, we are unable to obtain the person's authorization, or to release information about a death we believe may be the result of criminal conduct.

Coroners, Medical Examiners and Mortuaries: We may disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death of a person or aid in their investigation of a death.

Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.



When This Medical Practice May Not Use or Disclose Your Health Information

Right to request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health insurance by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend it in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

Right to Accounting Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs "Treatment," "Payment," "Health Care Operations," "Notification of Communication with Family," and the 10 items listed under "Special Situations That Do Not Require Your Authorization" in this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to Revocation. You have the right to revoke your authorization for the use or disclosure of your health information except to the extent that action has already been taken.

If you would like a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Signature: _____ Date: _____