ELITE MOTION
PHYSICAL THERAPY AND SPORTS MEDICINE

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact information for appointments, billing, and updates

Email: _____ Cell #: _____

Home#: _____ Work#: _____

Social Security: _____ Date of Birth: _____ Age _____ Sex: _____

Emergency Contact _____

Telephone #_____ Relation to Patient _____

Employment Status: Full-time/ Part-time/ Unemployed/ Retired/ Full time student/ Part-time student

Employer _____ Occupation _____

Are you currently at a skilled nursing facility or receiving home health care? YES / NO If yes, please provide the following:

Facility Name: _____ Phone: _____

Address: _____ Contact person _____

❖ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

By signing this, you acknowledge receipt of the Notice of Privacy Practices of Elite Motion Physical Therapy and Sports Medicine. Our notice of privacy provides information about how we may use and disclose your protected health information.

SIGNED: _____ DATE: _____

Patient Health Questionnaire

1. When did your symptoms start? Date: _____

2. In the past year, have you had two or more falls OR any fall with an injury? ☑ **Yes** ☑ **No**

3. How often do you experience your symptoms?

- Constantly (79-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

4. What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling
- Sore

4. How are your symptoms changing?

- Constantly (79-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)

5. Rate you pain.

1 2 3 4 5 6 7 8 9 10

6. What makes your pain worse?

_____

7. What decreases your pain? (Example: certain positions of rest, hot or cold packs, medication, etc.)

_____

8. Have you ever had any of the following:

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Dizziness/Vertigo
☐	☐	Heart Attack	☐	☐	Migraines
☐	☐	Stroke	☐	☐	HIV
☐	☐	Cardiac arrhythmias	☐	☐	Cancer
☐	☐	Pacemakers	☐	☐	Hepatitis
☐	☐	Seizures	☐	☐	Metal implants
☐	☐	Osteoporosis	☐	☐	Allergy to Tape
☐	☐	Osteoarthritis	☐	☐	Allergy to Latex
☐	☐	Rheumatoid arthritis	☐	☐	Hypersensitivity to heat
☐	☐	Diabetes	☐	☐	Hypersensitivity to ice

☐ Other:_____

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Welcome Letter

Dear Patient,

Welcome to Elite Motion Physical Therapy and Sports Medicine Center. We are excited about helping you feel better. Please let us know if you have any questions or comments, as we value and appreciate your opinion.

Please review the several important announcements outlined below, about the financial aspect of our relationship before we start your treatments. We hope this will minimize any misunderstandings.

1. We ask you NOT to schedule Physical/Occupational therapy appointments on the same day as your medical doctor appointments with Congress Medical. Many times, insurance companies do not pay for services on the same date and thus, we will need to collect the payment from you personally.

2. There will be a $25 fee for any returned checks.

3. Cancellations must be done 24 hours prior to scheduled appointments. If you fail to cancel in a timely manner, you are subjected to a $50 cancellation fee. The same fee applies for missed appointments.

4. We ask all Medicare patients schedule a medical doctor appointment every 30 days while they are receiving outpatient physical therapy and obtain a prescription. This rule is in accordance with Medicare guidelines and to insure reimbursement for our services rendered, failure to do so may result in the patient paying for their treatment.

5. Please arrive promptly for your scheduled appointment time. Being tardy decreases your treatment time, delays your therapists schedule and you may potentially have to be rescheduled.

We thank you for choosing Elite Motion as your rehabilitation clinic and we look forward to helping you during your road to recovery.

I agree to the above statements and if applicable, will fulfill my obligations accordingly to it.

_____ _____

Signature Date

Barry I. Shafer, PT, DPT, ATC
Director,
Elite Motion Physical Therapy and Sports Medicine

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Consent to Therapeutic Procedures

I, , hereby consent to the therapeutic procedures outlined below, to be performed by Elite Motion Physical Therapy and Sports Medicine Center.

_____ Evaluation and treatment of nerve, muscle, and skeletal dysfunction and/or pain
_____ Evaluation and treatment of functional loss\
_____ Other: _____

These procedures have been explained to me in terms that I can understand and include the following about the proposed evaluation and treatment.

1. The nature and extent of the evaluation procedure to be performed
2. Any risks involved, if any, in evaluation or treatment
3. Treatment may include, but is not limited to:
    a. Joint and soft tissue mobilization
    b. Exercise including stretching, strengthening, and balance/coordination training in the clinic. Home exercises will be developed and given in writing if requested.
    c. Functional retraining and including postural and body mechanics training, gait training, and other lost functions that will be identified in the evaluation process
    d. Modalities such as heat, ice, electrical stimulation, iontophoresis, and ultrasound.
    e. Special procedures such as taping, orthotics, and neuromuscular electrical stimulation.

If home exercise equipment such as exercise bands, foam rollers, or exercise balls are prescribed by my therapist, I understand that I may purchase them from this facility or obtain them from other sources.
I understand that I may consult with other therapists and/or physicians at any time regarding my condition, and I have the right to refuse any therapeutic procedures and treatment at any time.
Any questions I thought were important in deciding whether or not to undergo evaluation treatment have been answered to my satisfaction. I understand I may ask additional questions at any time.
I understand no assurance of a successful outcome or guarantee of success has been given to me.
I certify that I have read the above consent statement, that I understand the explanation of the procedures, and that this consent is given freely, voluntarily, and without reservation.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Physical Therapist Signature Date

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289 W. HUNTINGTON DRIVE
ARCADIA, CA 91007
TEL.(626) 396-8150 FAX.(626) 446-0495

800 S. RAYMOND AVE. 3RD FLOOR
PASADENA, CA 91105
TEL. (626) 795-0800 FAX. (626) 795-0854

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

This medical practice is required and permitted to make uses and disclosures of an individual's personal health information for purposes of treatment, payment, and health operations. It is necessary to share specific and appropriate levels of confidential information about an individual, for example: when submitting claims to insurance companies, retaining records in our office concerning the individual's treatment, or the sharing of information between staff members to process paperwork related to office operations.
Other purposes listed below are either permitted or required to sue or disclose confidential information without the individual's written authorization:

a.) Uses and disclosures for public health activities
b.) Reporting about victims of abuse, neglect, or domestic violence
c.) Disclosures for health oversight activities
d.) Disclosures for judicial and administrative proceedings
e.) Disclosures for law enforcement purposes
f.) Uses and disclosures about decedents
g.) Uses and disclosures for cadaveric organ, eye, or tissue donation purposes
h.) Disclosures to avert a serious threat to health or safety
i.) Uses and disclosures for specialized government functions

Others uses and disclosures will be made only with the individuals written authorization and that the individual may revoke such authorization. This office also may contact individuals and may leave messages to provide appointment reminders or information regarding treatment. The federal government has granted patients several new rights under the privacy regulation. These are as follows: The right to request restrictions on certain uses and disclosures, for example: an individual may request that this office not leave messages with other family members or on a home voice-mail system regarding certain treatments. Please note that the practice not required to all requested restrictions.

a.) The right to receive confidential communications, for example: on a home voice-mail system
b.) The right to inspect and copy protected health information, for example: clinical records, billing records, or other records used to make decisions regarding your care and treatment.
c.) The right to receive an accounting of disclosures of protected health information, for example: disclosures permitted or required by the office to be made in the ordering of a needed medical test.
d.) The right of an individual's receiving notice electronically to obtain a paper copy of that notice.

This practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information, and this practice is also required to abide by the terms of this notice, and we reserve the right to change the terms of this notice and make new notice provisions effective for all confidential information that we maintain. Any revised notices will be requested.