REHAB SPECIALISTS
WWW.REHABSPECIALISTSINC.NET

10635 Santa Monica Blvd Suite 165 Los Angeles, CA 90025
2730 Wilshire Blvd Suite 533 Santa Monica, CA 90403
5359 Balboa Blvd Suite A Encino, CA. 91316
4560 Admiralty Way Suite 300 Marina Del Rey, CA. 90292

(310) 273-0877 Phone
(310) 273-1189 Fax

Dear New Patient,

Welcome to Physical Therapy!

It is our pleasure to meet you. We want to make your time here a pleasant and enjoyable experience.

Our goal is to help you improve movement and function, relieve pain, and expand your movement potential. Through evaluation and individualized treatment programs, Physical Therapists can both treat existing problems and provide preventive health care for people with a variety of needs. Our staff includes Physical Therapists, Massage Therapists, Certified Pilates Instructors, Yoga Instructors, and a Feldenkrais Practitioner. We offer aquatic therapy as well in a warm fresh water pool located just blocks from our Santa Monica location. Our office staff is friendly and ready to assist you with any of your insurance or administrative questions.

Treatment may include hands-on mobilizing stiff joints and tissue, exercise, stretching, aquatic exercise and education. The goals of Physical Therapy are to restore or achieve optimal movement and function and to relieve pain.

You should notice changes in how your body is functioning during or after therapy. It is always good to give feedback to your Therapist regarding any changes in your symptoms, good or bad, so we may modify your treatments appropriately.

Our office hours are: Monday-Thursday 7:00 AM - 7:00 PM.
Friday 7:00 AM - 5:00 PM
Saturday Varies

Please keep your scheduled appointments and try to make your appointments on time. While we understand that circumstances arise, changing your time without notifying us may affect the waiting time of our other patients. If, for any reason, you cannot make your scheduled appointment, please call our office at (310) 273-0877. If you have any questions, please do not hesitate to ask.

Again, welcome to Rehab Specialists!

Sincerely,

Gail Pekelis, MA, PT, CLT

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Patient name: _____ **Gender:(M)__(F) __ Birthdate:** ____/____/____ **SS#** _____-____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: ( ) _____ **Work Phone: ( )**_____ **Email:** _____

Employer: _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

***How did you hear about us?** _____

Referring Physician: _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Phone: ( ) _____

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PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your rights under the law.

With my consent, Gail Pekelis, MA, PT, CLT., and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Gail Pekelis, MA, PT, CLT., and staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my physical therapy care.

With my consent, Gail Pekelis, MA, PT, CLT., and staff may e-mail or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and advertisements for our services.

I have the right to request that Gail Pekelis, MA, PT, CLT., and staff restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, you consent to use and disclose protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. If I do not sign this consent, Gail Pekelis, MA, PT, CLT., and staff may decline to provide treatment to me.

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The Practice has a Notice of Privacy Practices and I have had the opportunity to review this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.**
- **The patient may revoke this Consent in writing with a verifiable signature on file, at any time and all future disclosures will then cease.**
- **The Practice may condition receipt of treatment upon the execution of this Consent.**

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Print Name of Patient **Relationship to Patient**

_____ **Witnessed By:**_____
Print Name of Legal Guardian **Practice Representative**
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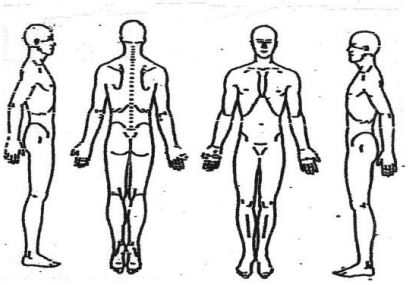
Patient Name: _____ **DOB:**_____ **Date:** _____
Are you undergoing Home Health Care at this time? (Nurse, Physical Therapy, etc.) **YES** **NO**
(If you are unsure how to answer this question, please talk to the receptionist)

1. **Describe your symptoms:**_____
   a. **When did your symptoms start?**_____
   b. **How did your symptoms begin?**_____
2. **Circle how often you experience your symptoms:**
   Constantly (76-100% of the day) **Occasionally (26-50% of the day)**
   Frequently (51-75% of the day) **Intermittently (0-25% of the day)**
3. **Circle what describes the nature of your symptoms:**
   Sharp **Shooting** **Dull ache** **Burning** **Numb** **Tingling**
4. **Circle to indicate how your symptoms are changing:**
   Getting Better **Not Changing** **Getting Worse**



Indicate where you have pain or other symptoms with an X in the area on the body

5. **During the past 4 weeks:** **none** **unbearable**
   a. **Indicate the average intensity of your symptoms:** **0 1 2 3 4 5 6 7 8 9 10**
   b. **Circle how much the pain has interfered with your normal work (including both work outside the home, and housework):**
   Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**
6. **During the past 4 weeks, how much of the time has your condition interfered with your social activities (visiting with friends, relatives, etc.)?**
   All of the time **Most of the time** **Some of the time** **A little of the time** **None of the time**
7. **In general, would you say your overall health right now is:** **Excellent** **Very Good** **Good** **Fair** **Poor**
8. **Circle who you have seen for your symptoms:** **Medical Doctor** **Chiropractor** **Physical Therapist** **No One** **Other**
   a. **What treatment did you receive and when?**
   _____
   b. **Circle what tests you have had for your symptoms, and please include the date of the test:**
   X-Ray/Date:_____ **MRI/Date:**_____
   CT/Date:_____ **Other/Date:**_____
9. **Have you had similar symptoms in the past?** □ **YES** □**NO**
   a. **If you have received treatment in the past for the same or similar symptoms, who did you see?**
   _____
10. **What is your occupation?**_____
    a. **If you are not retired, a homemaker, or a student, what is your current work status?**_____

Patient Signature:_____**Date:**_____

Patient Name:_____**Sex:**_____**DOB:**_____

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1. **Have you ever had?: (If yes, please explain)**

High Blood Pressure	NO/YES	_____
Heart or Circulation Disorders	NO/YES	_____
Seizures	NO/YES	_____
Dizzy Spells	NO/YES	_____
Diabetes	NO/YES	_____
Cancer	NO/YES	_____
Arthritis/Osteoarthritis	NO/YES	_____
Osteoporosis	NO/YES	_____
Immune Deficiency Disease	NO/YES	_____
Other	NO/YES	_____

2. **Please list surgeries you have had along with procedure and dates, if possible:**
   _____
   _____
   _____

3. **Please list recent diagnostic studies (CT Scan, MRI, X-Ray), with dates and facility, if possible:**
   _____
   _____
   _____

4. **Do you have any METAL anywhere in your body, pins/plates post fracture, or pacemaker (other than teeth)? NO/YES. If YES, please describe:**
   _____

5. **For women only: Are you currently pregnant? NO/YES Date of last menstrual cycle: _____/_____/_____**

6. **Do you have any abnormal trouble with vision? NO/YES with hearing? NO/YES**

7. **List any allergies you may have:**
   _____

8. **Have you ever taken steroids or anti-coagulants for an extended period of time? NO/YES**

9. **Have you had an unusual weight gain or loss? NO/YES**

10. **List any medications you are now taking:**
    _____
    _____

11. **Have you ever had physical therapy treatments before? NO/YES**
    If YES, please indicate where, when, and for what problem:
    _____
    _____

12. **Describe briefly the history of your present <u>ACCIDENT, INJURY, OR ILLNESS:</u>**
    Onset date: _____Description:_____
    _____

Date of next Doctor appointment:_____/_____/_____

Welcome to Physical Therapy Rehabilitation

We urge you to please feel free to discuss any questions you may have regarding the following policies with our patient account personnel. We are here to assist you with your financial questions.

CASH PATIENTS: Payment is made at the time of each visit. You have the option of leaving a credit card number on file to charge for any late cancellation fees. The charge of $75 will be applied for any late cancellations (made under 24 business hour notice).

ALL PATIENTS: We will, **as a courtesy**, verify your insurance coverage and bill your primary insurance carrier. It is your responsibility to meet your deductible and/or any co-payments that your insurance policy does not cover. All co-payments are payable at the time of each visit, unless other arrangements have been made prior. If we do not receive payment from your insurance carrier within **45 days of billing**, you will be fully responsible for any outstanding balance.

We ask that you furnish us with the following information: A prescription for physical therapy services from your medical doctor, and complete billing information so that your insurance billing will be as efficient as possible.

Medicare patients: We will bill Medicare. Please remember that you will need a **valid prescription every 30 days** to continue physical therapy services per Medicare guidelines or you may be responsible for any amount not allowed by Medicare and/or a deductible amount. As a courtesy, we will bill your secondary insurance.

Blue Cross patients: We are a participating provider for Blue Cross of California. We will bill all claims for you. You are responsible for your deductible, coinsurance and copayments.

HMO/PPO patients: We are an HMO provider for UCLA Medical group and Access Medical group only. You will need a referral/authorization from your primary care physician and/or medical utilization review board. This must be in writing and should be obtained before your first visit. If you do not have this referral/authorization, you will be responsible for the full payment amount.

MISSED APPOINTMENTS: In our busy lives, especially with work and children, sometimes you may forget or miss an appointment. This unfortunately causes a lot of scheduling and time allocation problems for us and denies another patient timely access for treatments. **If you cannot keep your appointment, you must notify us 24 business hours in advance not including weekends. Cancellations less than 24 hours in advance will be subject to a $75 charge, including cash patients. If you are 30 minutes late for your scheduled appointment, you will be responsible for $75 out of pocket.**

I understand the cancellation policy at Rehab Specialists, Inc. _____ (Initials)

- You are financially responsible for all services not covered by your insurance company.
- At each visit, you will be expected to pay the amount verbally quoted to us by your insurance company, including outstanding deductibles.
- We accept cash, check, money orders, and credit cards **EXCEPT AMEX**.
- Patient responsibility balances over 30 days will be charged an **18%** interest fee.
- There is a $25 fee for returned checks.

I understand that during the course of my Physical Therapy treatment, it may be necessary for my treating therapist to utilize supplies that pertain to my particular condition. I understand that these items are not billable to my insurance company and thus are my financial responsibility.

Thank you for your cooperation.

I have read and understand the above policies of Women's Physical Therapy Rehabilitation, Inc. /Rehab Specialists Inc.

Signature:_____ **Date**:_____

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PATIENT NAME: _____ DOB: _____

APPOINTMENT REMINDER AUTHORIZATION FORM

☐ Email - Email address: _____

☐ Text Message- Mobile # : _____

☐ Voice Message - Phone # : _____

*** **Please choose 1 option*****

Patient / Legal Guardian Signature: _____ Date: _____

MISSED APPOINTMENTS: In our busy lives, especially with work and children, sometimes you may forget or miss an appointment. This unfortunately causes a lot of scheduling and time allocation problems for us and denies another patient timely access for treatments. **If you cannot keep your appointment, you must notify us 24 business hours in advance not including weekends and holidays. Cancellations less than 24 hours in advance will be subject to a $75 charge, including cash patients. If you are 30 minutes late for your scheduled appointment, you will be responsible for $75 out of pocket. An appointment reminder is a courtesy. Please be aware you are still responsible to keep track of your scheduled appointments.**

Credit Card Pre-Authorized Healthcare Form

I _____ authorize Rehab Specialists Inc. To keep my signature on file *and* to charge my credit card as indicated below:

Check One: □ Mastercard □ Visa □ Discover

Check all that apply

□ Balance of charges not paid by insurance within 90 days and not to exceed **$**_____ for (indicate one)

- □ This visit only _____(date)
- □ All visits for a year from date signed

□ Recurring charges (ongoing treatments) of **$**_____

- □ Date range from_____to_____.
- □ All visits for a year from date signed

■ Cancellation fee **$75** per visit

If you cannot keep your appointment, you must notify us 24 business hours in advance not including weekends. Cancellations less than 24 hours in advance will be subject to a **$75** automatic charge. All visits for a year from date signed

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name **Email**

Cardholder Name

Cardholder Billing Address

City **State** **Zip**

Credit Card # **Expiration Mo.** **Yr**

Signature **Date**