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

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

rehab_specialists_inc

rehabspecialistsinc.net

Signatures will be taken in office. Thank you for completing this in advance!

Patient name:_____Gender (M)___(F)___Birthdate:____/____/____

Address:_____ City: _____State:_____Zip:_____

Cell: (_____)_____-_____Email:_____How did you hear about us?_____

☐ **By checking this box, you agree to receive text messages from Rehab Specialists, which includes reminders. Reply STOP if you would like to unsubscribe and to stop receiving text messages.**

Occupation_____Employer_____

Referring Physician:_____Phone:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

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 Patent Rights section describing your nights under the law.

With my consent, Gail Pekels, 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 Notion of Privacy Practices for a more complete description of such uses and disclosures

With my consent, Gal Pekels, 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

I have the right to request that Rehab Specialists Inc., 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

You have the night 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, Rehab Specialists Inc, 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 or Legal Guardian Relationship to Patient

Witnessed by Practice Representative:_____

Patient Name:_____Date of Birth:_____

Health History:

****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)

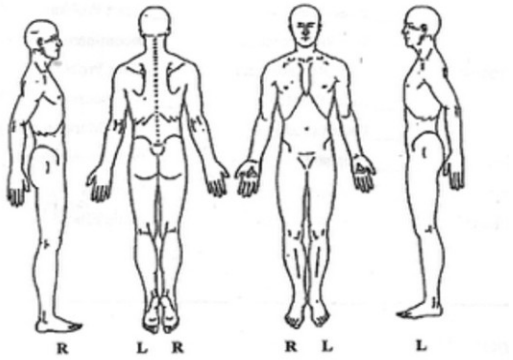
1. Describe your symptoms:_____

   a. When did your symptoms start? _____

   b. How did your symptoms start?_____

_____

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



2. Check 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

5. During the past 4 weeks: 0 - none 10- unbearable

   a. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

   b. Check off 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. Check off who you have seen for your symptoms: If so when?_____

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ 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:_____

Date of next Doctor's appointment_____

Patient Initials: _____ Date: _____

Patient Name:_____Date of Birth:_____

9. Have you had similar symptoms in the past? □ YES / □ NO

If you have received treatment in the past for the same or similar symptoms, who did you see and when?

_____

10 .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	_____

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

_____

_____

12. Do you have any post-op restrictions or protocols from your Doctor?

_____

_____

13. Do you have any METAL anywhere in your body, pins/plates post fracture, or pacemaker (other than teeth)? If YES, please describe:

_____

_____

14. For women only: Are you currently pregnant? □ NO/ □ YES Date of last menstrual cycle_____

15. Do you have any abnormal trouble with vision? □ NO/ □ YES with hearing? □ NO/ □ YES

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

17. Have you had an unusual weight gain or loss? □ NO/ □YES

18. List any medications you are now taking:

_____

_____

19. Have you ever had physical therapy treatments before? If YES, please indicate where, when, and for what problems. What type of treatments?

_____

_____

20. Briefly describe the history of your Accident, injury or illness: Onset Date:_____

_____

_____

Patient Initials: _____ Date: _____

MISSED APPOINTMENTS / Financial Responsibility

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. Two consecutive no shows or habitual no shows will result in all appointments cancelled.

If you cannot keep your appointment, you must notify us 2 business days in advance not including weekends or holidays. Cancellations less than 2 business days in advance or Same Day "No Shows" will be subject to a $75 charge. If you are late for more than half of your scheduled time this will be considered a no show.

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

We will as a courtesy, verify your insurance coverage and bill your primary insurance carrier. It is your ultimate responsibility to know your benefits with your insurance and advise you to give them a call. It is your responsibility to meet your deductible and/or any co-payments and co-insurance that your insurance policy does not cover. All co-payments, deductibles, co-insurances, and outstanding balances are payable at the time of each visit. If we do not receive payment from your insurance carrier within 45 days of billing you will be full responsible for any outstanding balance.

You are financially responsible for all services not covered by your insurance company.

We accept credit cards (EXCEPT AMEX) and checks. 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.
We do not bill DME.

I have read and understand the policies of Rehab Specialists Inc and give permission to keep my signature on file and charge my credit card as indicated:

- ☐ **Balance of charges not paid by insurance within 90 days**
- ☐ **Recurring charges (such as co-pays)**
- X **Cancellation/No Show fee charges**

Cardholder Name _____

Cardholder Billing Address _____ **City** _____ **State** _____ **Zip** _____

DO NOT WRITE CREDIT CARD #
(SCAN IN TERMINAL ONLY) _____ **EXP** _____

Signature _____ **Date** _____

Patient Consent Form for Video Surveillance in Common Areas:

Purpose of Video Surveillance
To enhance the safety and security of our patients, staff, and property, Rehab Specialists Inc., have installed video surveillance cameras in common areas of our facility. These cameras will be positioned in common areas, including the front desk area, the waiting room, reception area, gym, pool, and hallways.

Scope of Surveillance
Areas Covered: Surveillance cameras are installed in common areas only. Cameras will not be placed in private areas such as examination rooms or restrooms.
Purpose: The cameras will be used for security and safety purposes, including monitoring the facility, preventing and investigating incidents, and ensuring compliance with health and safety regulations.

Privacy and Data Handling
Access: Video footage will be accessed only by authorized personnel and will be stored securely.
Retention: 30 days
Requests for Footage: Patients or visitors may request to view footage related to specific incidents involving them, subject to privacy and legal considerations.

Your Consent
By signing this form, you acknowledge and agree to the following:
- You have been informed about the purpose and scope of the video surveillance.
- You consent to the operation of video surveillance cameras in the common areas of Rehab Specialists and you acknowledge that you have no right of privacy in these areas.
- You understand that cameras will not be placed in private or sensitive areas.
- You have the right to withdraw your consent at any time by notifying Rehab Specialists in writing. Please note that withdrawing consent may impact the security measures in place and treatment at our facility.

Acknowledgment and Signature
I, the undersigned, have read and understood the information provided about the video surveillance system at Rehab Specialists Inc. I consent to the use of video surveillance cameras in the common areas as described.

Patient Name:_____ Patient Signature:_____

Date: _____

If signed by a representative:

Representative Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____