EVERGREEN
PHYSICAL THERAPY

111 SOUTH HUDSON AVE PASADENA, CA 91101
Phone (626) 683 - 8536 Fax (626) 683 - 8236
www.EvergreenPT.net

PATIENT REGISTRATION

Patient's Name _____ Date of Birth ____/____/_____

Guardian (If minor) _____ Relationship _____

Patient's Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

I would like to receive appointment reminders via ☐ Email ☐ Text or ☐ Phone Call

Employer _____ SSN_____-_____-_____

How did you hear about us? _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Referring Physician _____ Phone _____

Diagnosis _____

Date of Injury / Onset / Surgery: _____

Was This Related to an Accident? Auto/ Work / Other Date of Accident _____

Have you had prior Physical Therapy, Occupational Therapy, Chiropractic, or Acupuncture visits this year? Yes / No If yes, how many visits? _____

Are you currently, or have you received Home Health Services this year? Home Health services can be, but are not limited to nurse, physical therapy, occupational therapy, wound care, IV or other medication administration. Yes / No

If yes, have you been discharged? Yes / No Date of Discharge _____

* Please note that if you have Medicare and are currently receiving Home Health services, you may not begin outpatient physical therapy without first being discharged from Home Health.

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PATIENT NAME:_____

_____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

_____ *Authorization for Signature on File and release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be as valid as an original.

_____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay directly to the above named practice.

_____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

_____ *Notice of Privacy Practices*

I have read and fully understand the named practice's Notice of Practices. I understand that the above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that the above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Patient or Guardian Signature **Date**

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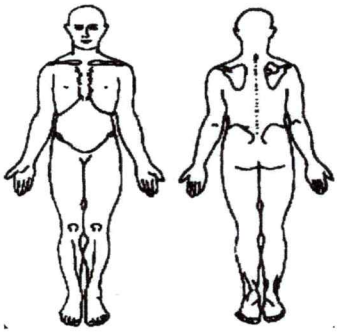
MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____

*HEIGHT: _____ *WEIGHT: _____ ONSET DATE OF INJURY: _____

CONDITION/TYPE OF INJURY OR CAUSE: _____
(Is this due to an auto accident?)

TYPE OF SURGERY & DATE _____



PLEASE MARK AREA(S) OF CONCERN

HAVE YOU HAD ANY IMAGING PERFORMED:

- ☐ X-Ray
- ☐ CT SCAN
- ☐ MRI
- ☐ Ultrasound

Date of Imaging: _____

HAVE YOU RECENTLY NOTED:

- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Pregnant/IUD
- ☐ Pain at Night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Leg Cramps when Walking
- ☐ Fatigue
- ☐ Numbness/Tingling
- ☐ Change in Vision/ Hearing
- ☐ Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Surgeries
- ☐ Sprains/ Strains
- ☐ Heart Problems
- ☐ Circulation/ Clots
- ☐ Fainting
- ☐ Difficulty Swallowing
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma/ Breathing Problems
- ☐ Easy Brusing/Bleeding
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Arthritis
- ☐ Lung Disease
- ☐ Leg/Ankle Swelling
- ☐ Urinary Problems/Infections

EXPLAIN AND GIVE APPROXIMATE DATES FOR ANY ITEMS INDICATED ABOVE: _____

_____

*TYPE OF ALLERGIES (IF ANY) : _____

* LIST OF CURRENT MEDICATIONS	*DOSE	*FREQUENCY
_____	_____	_____
_____	_____	_____

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

*Are you taking VITAMIN D? ☐ YES ☐ NO

*Describe the pain in the last 24 hours: DURING ACTIVITY _____ (SCALE OF 1-10) DURING REST _____ (SCALE OF 1-10)

What makes the pain better or worse? _____

*Have you had 2 or more FALLS within the last 12 months? ☐ YES ☐ NO

*Have you had at least one FALL WITH AN INJURY in the last 12 months? ☐ YES ☐ NO

What are your goals for Physical Therapy? (PLEASE USE BACK OF FORM)

X_____ _____
PATIENT OR AUTHORIZED SIGNATURE DATE

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Important Notice for Medicare Patients

Outpatient physical therapy is not a covered service by Medicare if you are concurrently receiving home health services.

Home health services may include, but are not limited to

- Physical therapy
- Occupational therapy
- Speech therapy
- Nurse services
- Wound care, bandage changes
- Administration of medication or immunization shots
- Intravenous therapy

If you are unsure whether the services you are receiving at home qualify as home health care, please contact your Medicare plan and your home health agency.

____ No, I am not currently receiving home health services

____ Yes, I am currently receiving or have received home health services in the last year. Start date_____ End Date_____

If yes, please note that we require a copy of your signed home health discharge before you can begin outpatient physical therapy services.

By signing this document I, _____, agree to notify Evergreen Physical Therapy Specialists, Inc. if/when I begin any home health services throughout the duration of my outpatient physical therapy treatment. I understand that once I start home health services, I cannot receive outpatient physical therapy services.

_____ _____

Signature of Patient date

Coronavirus Disease 2019
Non-personnel Screening Questionnaire

All non-personnel (patients, visitors, vendors, etc.) will be asked to complete this form or to verbally attest to the questions posed on each in-person visit. A daily log will be maintained to record verbal attestations.

Please check the **Yes** or **No** boxes; do not check both the yes and no boxes.

1. Have you tested positive for COVID-19 in the past 10 days? Yes ☐ No ☐
2. Are you currently awaiting results from a COVID-19 test? Yes ☐ No ☐
3. Have you been diagnosed with COVID-19 by a licensed healthcare provider in the past 10 days? Yes ☐ No ☐
4. Have you been exposed to COVID in the past 10 days? Yes ☐ No ☐
5. Have you had any these symptoms in the past 48 hours?

Fever over 100.4° or chills	Yes ☐ No ☐
Persistent cough	Yes ☐ No ☐
Shortness of breath/difficulty in breathing	Yes ☐ No ☐
Fatigue	Yes ☐ No ☐
New loss of taste or smell	Yes ☐ No ☐
Sore throat	Yes ☐ No ☐
Muscle or body aches	Yes ☐ No ☐
Congestion or runny nose	Yes ☐ No ☐
Nausea or vomiting	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐
Headaches	Yes ☐ No ☐

In order to comply with OSHA's Emergency Temporary Standard for exempt outpatient providers we are prohibited from allowing COVID-19 positive or suspected positive individuals from entering our facility past our screening point. We will make every attempt to provide patient treatments via telehealth, in these situations if permitted by law. Should this not be available we will provide a list of potential facilities that may be available for continued treatment during this restriction period.

Name: _____ Date: _____

HEALTH INFORMATION PRIVACY NOTICE

Please note in Section 5 you still may choose which special uses apply to your facility (in red). Please choose either this form or the OCR Privacy Notice BOM 140b.

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.

Please Review This Document Carefully.

About Protected Health Information (PHI).

In this Notice, "we", "our" or "us" means this *FACILITYNAME* and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information, we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

1. Treatment

   We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optimal care is rendered.

2. Payment Involving a Third Party Payer

   After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payer may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

3. Payment Exclusive of a Third Party Payer (fully self-pay)

   If you choose to pay for your services, in full, without involving a third party (insurer, employer, etc.) you may request that we do not disclose any information regarding your services for payment purposes.

4. Health Care Operations

   We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of actual patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

5. Special Uses

   We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

   - Update your workers compensation case worker or employer
   - *Remind you of appointments*
   - *Carry out follow ups on home programs that you have been taught*
   - *Advise you of new or updated services or home supplies (you can choose to opt-out of receiving any notices of this kind)*
   - *Release equipment and/or supplies to your designee*
   - *Carry out follow ups on your home programs or discharge planning*
   - *Advise you of new or updated services or home supplies via telecommunication or via a newsletter (you can choose to opt-out of receiving information of this nature from us)*
   - *Carry out research that does not directly identify you*
   - *Carry out marketing functions such as providing nominal promotional gifts (you can choose to opt-out of receiving any marketing information or items from us)*
   - *Contact you regarding fundraising projects that we are engaged in (you can choose to opt-out of any fundraising project notification that we engage in)*

Note: If we receive direct or indirect financial remuneration from a third party for marketing a product or item or for any fundraising we are engaged in we will offer you the opportunity to 'opt out' from receiving any of these materials.

6. Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

- If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- We may use your PHI in an emergency if you are not able to express yourself
- If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research; *FACILITYNAME* will always obtain an authorization from you even though it is 'permitted' without one

Required:

- When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- To report neglect, abuse or domestic violence
- To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- In judicial or administrative proceedings such as a response to a valid subpoena
- When properly requested by law enforcement officials or other legal requirements such as reporting gunshot wounds
- To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

Some state regulations are more stringent than federal privacy regulations so we comply with those laws.

7. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

8. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy Your PHI
  You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within *thirty (30) days*, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.

- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that right. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record
- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually. We have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- You have a right to be informed of a breach your protected health information
  We are required to notify the patient by first class mail or by e-mail (if indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than *sixty (60) days* following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

a) A description of the breach, including the date of the breach and the date of its discovery, if known
b) A description of the type of unsecured protected health information involved in the breach
c) Instructions regarding the measures the patient should take to protect him/her from potential harm resulting from the breach
d) Correction action *FACILITYNAME** has/will take to investigate the breach, mitigate losses, and protect the patient from further breaches
e) *FACILITYNAME** contact information, including a toll-free telephone number, e-mail address, Web site or postal address to allow for additional questions

- You Have a Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us by contacting our HIPAA officer noted in Section 10, or to the:

  U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate against you if you file a complaint about us. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.
- The Patient Has the Right to Receive a Copy of the Privacy Notice
  *FACILITYNAME** is obligated to provide the patient with a copy of its Notice of Privacy Practices and to post the Notice in a conspicuous place for patients to access as well as on our website. We have the right to change the Notice to comply with policy, rules or regulatory changes; we are obligated to give new notices to current and subsequent patients as changes are made. We are required to maintain each version of a Privacy Notice for a minimum of six (6) years.

9. Some of Our Privacy Obligations and How We Perform Them
   - We are required by law to maintain the privacy and security of your protected health information
   - We will let you know promptly if a breach that may have compromised the privacy or security of your information
   - We must follow the duties and privacy practices described in this notice and give you a copy of it
   - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

10. Contact Information
    If you have questions about this Notice, or if you have a complaint or concern, please contact:

    Name: David Johnson
    Address: 200 E. Del Mar Blvd. Ste. 302
    Pasadena, CA 91105
    Phone: (626)683-8536

11. Effective Date: This revised notice takes effect on 10-2-2015