ASPIRE
PHYSICAL THERAPY
& SPORTS PERFORMANCE

Whom may we thank for referring you?

☐ Doctor_____ ☐ Family Member_____

☐ Friend_____ ☐ Website _____ ☐Other_____

Last Name:	**First Name:**	**Middle Name:**

Birth date: / /	**Sex:** ○ Male ○ Female	**Age**	**Home Phone Number :**	**Cell Phone Number:**

Street Address:	**City:**	**State:**	**Zip:**

Email Address:	**Primary Care Physician:**	**Physician Phone Number:**

Occupation:	**Emergency Contact Name:** **Phone Number:**

General Information

Insurance Information

Insurance carrier name:	**Subscriber/Member ID:** **Group # (if applicable):**	**Patient's relationship to Card Holder:**

Insurance Card Holder's name:	**Birth date:** / /	**Address of Card Holder:**

Do you have a prescription: ○ Yes ○ No	**Prescription Date:**	**Prescription frequency/# of visits:**

What is the injury/surgery:	**Date of onset/date of surgery:**
Previous treatment:	

Patient/Guardian Signature: _____Date: _____

Have you ever experienced any of the following conditions? Patient Name:_____

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Anemia/blood Disorder			Stroke			Sensitivity to Ice		
Arthritis			Falls			Sensitivity to Heat		
Bowel/bladder problems			Gynecologic Conditions			Lung Disorder		
Cancer			Headaches (>1 per week)			Neurological Disorder		
Depression			Hearing Problems			Osteoarthritis		
Diabetes			Hernia			Osteoporosis		
Dizziness			Kidney Problems			Rheumatologic Disorder		
Arterial Blockage of Legs			Liver/Kidney Condition			Thyroid Condition		
Deep Venous Thrombosis			Head Trauma			Vision Problem		
Heart Disease			Fractures			Have a pacemaker		
High Blood Pressure			Seizures			Have metal implants		

Medications Currently Taking	**How much/how often**
1.	
2.	

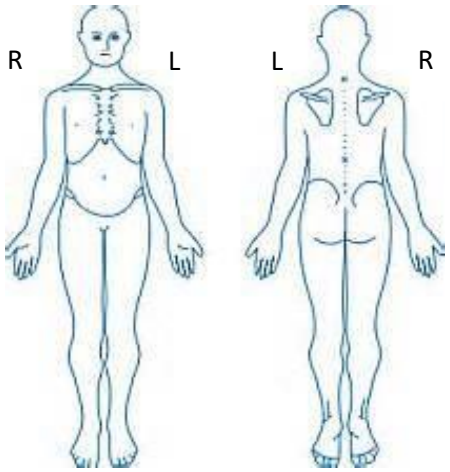
Please list any allergies you have-

Do you smoke? Yes No Alcohol consumption: daily weekly occasionally rarely never

Are you pregnant? Yes No Have you experienced recent unplanned weight loss? Yes No

Describe Diagnosis/Injury:

Please mark the area of discomfort



Rate the intensity of the pain at its <u>best</u>

(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Rate the intensity of pain at its <u>worst</u>

(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Which description are you experiencing?

Aching	Numbness	Stabbing
Burning	Dull	Pins and Needles

The above information is correct to the best of my knowledge.

Patient/Guardian Signature:_____Date:_____

Aspire Physical Therapy & Sports Performance
Tel: (818) 369-7620 · Fax: (818) 369-7621 · Email: admin@aspirephysicaltherapy.com

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review carefully.

Aspire Physical Therapy and Sports Performance Legal Duty

Aspire Physical Therapy and Sports Performance is required by law to protect the privacy of all patient health information. This policy states that all staff shall adhere to HIPAA regulations and protect our patient's personal health information at all times. Patient information will not be used outside of below disclosures without an authorization from the patient.

Uses and Disclosures of Health Information

Aspire Physical Therapy and Sports Performance uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Aspire Physical Therapy and Sports Performance may also use or disclose your health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Aspire Physical Therapy and Sports Performance may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam area and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

As our patient, you have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or operations. You may request in writing that we do not use or disclose your personal health information for treatment, payment, and operations except when specifically authorized by you, when required by law or in emergency circumstances. Aspire Physical Therapy and Sports Performance will consider all such requests on a case-by-case basis, but Aspire is not legally required to accept them.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint regarding HIPAA regulations, please contact Dr. Aaron McGuinness, PT, DPT, OCS.

*****PLEASE RETAIN THIS COPY FOR YOUR RECORDS*****

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Patient Consent/Disclosures to Health Information

I have read and fully understand Aspire Physical Therapy and Sports Performance (APT) Notice of Information Practices. I consent to treatment for physical therapy. I understand that APT may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations. I also understand APT will consider requests for restriction on a case-by-case basis, but ultimately does not have to agree to any.

**I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Aspire Physical Therapy and Sports Performance Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.*

Patient Insurance Responsibility

As a courtesy, APT will verify your insurance coverage. However, please be aware that payment collected is an estimated rate provided by the insurance company; they may process claims at a higher or lower rate at any time. It is advised that you personally check your insurance benefits before beginning treatment. All patient deductibles, co-pays, co-insurance, and cash services are due at the time of treatment. Patient acknowledges that if they are already receiving therapy elsewhere, including home health care, or have not been properly discharged from home health care they will be financially responsible for the services provided by APT.

**I hereby consent to all insurance benefits (Private, Medicare, and Worker's Compensation) to be paid directly to Aspire Physical Therapy and Sports Performance. I understand that if my insurance does not cover or approve payment for services provided then I am financially responsible and obligated to pay for all charges related to the services provided to Aspire Physical Therapy and Sports Performance.*

Late cancellation/No-show Fee

We request that you notify us by phone or text at 818-369-7620 or email at admin@aspirephysicaltherapy.com, **at least 24-hours** prior to your scheduled appointment. If you fail to keep your appointment or do not cancel 24-hours prior to your appointment time, you will be subject to a **$45** late cancellation/no-show fee.

**I understand the terms of this form and hereby state that I am financially responsible for charges incurred from cancellations or no shows, as well as take insurance responsibility.*

Patient Name _____

Patient/Guardian Signature: _____**Date** _____