NOTICE OF PATIENT INFORMATION PRACTICES

****THIS NOTICE DESCRIBES HOW YOUR PERSONAL MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.****

EVOLVE PHYSICAL THERAPY + ADVANCED WELLNESS'S LEGAL DUTY

Evolve Physical Therapy + Advanced Wellness is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Evolve Physical Therapy + Advanced Wellness may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, or for emergencies. We also provide information when required by law.

In any other situation, **Evolve Physical Therapy + Advanced Wellness's** policy is to obtain your written consent 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.

Evolve Physical Therapy + Advanced Wellness 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 areas and will be provided to you on your next visit. You may also request a copy of our Notice Of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

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 other related administrative purposes.

You may also request in writing that we are not to use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. **Evolve Physical Therapy + Advanced Wellness** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Evolve Physical Therapy + Advanced Wellness** may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services.

PATIENT RIGHTS

The following is our policy regarding the rights of the patients receiving service from ***Evolve Physical Therapy + Advanced Wellness***. Each patient has the right to:

A. Be fully informed of his/her rights as well as all rules and regulations of ***Evolve Physical Therapy + Advanced Wellness*** governing patient expectations.

B. Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.

C. Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment.

D. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

E. Be assured confidential treatment of clinical records and to approve or refuse their release to any individuals, except in the case of transfer to another health care facility, or as required by law or third party payment contracts.

F. Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.

G. Be informed by ***Evolve Physical Therapy + Advanced Wellness*** of the provision of the law regarding complaints and of procedures for registering complaints confidentially including, but not limited to the address and telephone number of the complaint receiving unit of the California Department of Health Services.

H. Be assured that personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

I. Be informed that these rights may be denied for good cause only by the attending Physical Therapist. Denial of such rights shall be documented by the attending Physical Therapist in the patient's clinical record.

Any complaints regarding denial of patients rights not satisfied after a discussion with **Evolve Physical Therapy + Advanced Wellness** must be registered in confidence with the California Department of Health Services. Upon request, the staff of **Evolve Physical Therapy + Advanced Wellness** will assist the patient to contact the appropriate office of the state agency.

Telehealth Visit Permission to Treat

I, _____ (Print name), consent to participating in a telehealth visit with a Physical Therapist, who is an employee of Evolve Physical Therapy. I understand that the evaluation and treatment of current medical condition(s) using a synchronous video and/or audio call is under the Physical Therapy scope of practice similar to a clinic visit and will be carried out by a licensed practitioner.

I understand that the telehealth session will use Zoom, a computer application that allows for encrypted video meetings. Encrypted meetings are private meetings between the Physical Therapist and the patient that keeps health information on a secure line, prevents hacking, and reduces invasion of privacy. I understand that the version of Zoom used for telehealth visits does not have a business contact to be HIPAA compliant, however, Zoom does follow HIPAA guidelines to ensure private health information is kept secure throughout the session. This private health information is not stored after completion. No recording of the session will be done unless verbal consent is given.

I understand the Physical Therapist will conduct the session in a space that is conducive for keeping health information private and maintain professional guidelines. I understand that no physical exam or manual therapy will be given during a telehealth visit and I agree to the Therapist's plan of care that may be modified for telehealth.

I have also signed the general consent form for treatment from the clinic, Evolve Physical Therapy. The current clinic policies apply to telehealth visits as well.

I understand that this telehealth visit will not be billed to my insurance and therefore must be paid in full before the start of care. All Medicare patients will also complete the attached Advance Beneficiary Notice of Noncoverage (ABN) in compliance with regulations. The Physical Therapist has the right to refuse treatment if payment is not received.

_____ _____

Signature Date

_____ _____

Witness Date

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PATIENT INFORMATION CONSENT AND CONSENT TO TREAT FORM

I hereby consent to having ***Evolve Physical Therapy + Advanced Wellness*** treat me.
I have read and fully understand the ***Evolve Physical Therapy + Advanced Wellness*** "Notice of Information Practices." I understand that ***Evolve Physical Therapy + Advanced Wellness*** 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 ***Evolve Physical Therapy + Advanced Wellness*** 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 ***Evolve Physical Therapy + Advanced Wellness***'s "Notice of Information Practices." I understand that I retain my right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Signature Date

It is your responsibility to arrive on time for all of your scheduled appointments. Evolve Physical Therapy + Advanced Wellness will provide you with a complimentary phone call or email to remind you of your upcoming appointments. Please let us know what form of the reminder you prefer.

I understand that I am responsible for arriving on time for all of my future appointments at Evolve Physical Therapy + Advanced Wellness. I also understand that I need to give 24hr notice for a cancellation or I may be subject to a <u>NO SHOW FEE of $95</u> for a PT visit or the full value or pack price for any cash service such as massage, gym, acupuncture, etc.

Please CALL me at (_____)_____or TEXT me at: (_____)_____or EMAIL me at:_____

I, _____ would prefer NOT to receive a reminder of any sort for my upcoming appointments. I understand that I need to give **24hr notice for a cancellation or may be subject to a no show fee of $95 for a PT visit or the full value or pack price for any cash service such as massage, gym, acupuncture, etc.**

_____ _____
Signature Date

Go Green

This original will be kept in your chart. A copy of this form is available upon request.

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CLINIC POLICIES

Name: _____ Date: _____

Welcome to ***EVOLVE PHYSICAL THERAPY + ADVANCED WELLNESS***. We look forward to serving all of your physical therapy + wellness needs. As a new patient with our office, we would like you to be familiar with our office policies concerning your scheduling and account while you are with us. Please feel free to ask any questions regarding the following.

1. Your insurance dictates whether or not it can or cannot be billed without a current prescription from your doctor.
2. You will meet your therapist at your first appointment. Please be ready to begin your appointment at your scheduled time. To be fair to all patients, we will not run over the allotted time period.
3. WE REQUIRE A 24HR NOTICE TO CHANGE OR CANCEL a scheduled appointment. ***If you fail to show or cancel your appointment without a 24-hour notice you will be charged. The charge is $95 for a physical therapy visit and $60 for a Tele-Health appointment***. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier. **For 'cash pay' visits**: you will be charged for the FULL visit- if you have a pack it will be the pack price otherwise it will be a one-time visit price. **Payment of missed and any future appointments will be due before your next appointment.**
4. Our office is happy to courtesy bill your insurance. We will also courtesy call your insurance to verify your PT benefits. As your insurance will make no guarantee of payment until the claim is received and processed, you will be financially responsible for all services unpaid by your insurance after 60 days. Your insurance company may require authorization or pre-certification for certain procedures and services. As a courtesy, we will contact your insurance company on your behalf. It always remains your responsibility to understand what your insurance policy covers and confirm directly that you have authorization and coverage for the services you receive. We may request your direct involvement in following up on authorization requests and delayed payments if your insurance becomes unresponsive to our inquiries. Direct intervention on the part of the patient often results in a more timely approval of services, prevents delays in treatment and expedites payment for your services.
5. "Cash Pay" services **cannot** be billed to insurance. We, the provider and you, the patient, cannot submit these services to your insurance company. We will collect for "Cash Pay" services after each appointment or session. Discounted Package services must be purchased in advanced. Our "Cash Pay" services include:
   - ***Acupuncture and Bodywork***
   - ***All therapy supplies and products including:***
   - ***Therabands, foam rollers, orthotics, etc.***
   - ***Wellness Appointments***
   - ***Gym Services***
   - ***Classes: 50 Shades, 30 Min Abs***
   - ***Golf Fit Program***
6. The patient's personal portion will be due after every visit and is collected at the front desk. ***Please be advised we are estimating your personal portion***. This is based on the information received when benefits were quoted by your insurance. Final balances will be determined once your insurance finishes processing. At that time, outstanding balances will be collected or overpayments will be refunded.
7. We do not accept liens or third party payors.
8. In the event any action is taken to enforce collection of this account, the presiding party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature _____ Date _____

Witness _____ Date _____

This original will be kept in your chart. A copy of this form is available upon request.

Patient Intake Questionnaire

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Date: _____

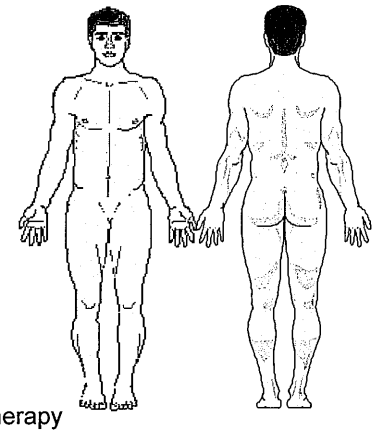
Patient's Name: _____ Age: _____ Sex: _____

1. What is the complaint that brought you here? _____
2. When did this complaint begin, or recently become worse? Approximate Date: _____
3. What caused this complaint? _____
4. What makes this complaint better? _____
5. What symptoms are you experiencing with this complaint?

☐ Swelling ☐ Loss of balance or coordination

☐ Loss of motion ☐ Numbness ☐ Pain: Draw pain areas on body diagrams ->

☐ Weakness ☐ Tingling ☐ Other (Specify)



6. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent
7. How much pain are you experiencing?

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

8. What tests have you had for this complaint?

☐ X-ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan

9. What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy

☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine-(Specify): _____

About your general health:

10. Please check all medical conditions that you <u>have</u>, or <u>have had</u>.

☐ Arthritis	☐ Cardiac History	☐ Stomach Disorder	☐ Headaches
☐ Cancer	☐ High Blood Pressure	☐ Anxiety	☐ Dizziness
☐ Diabetes	☐ Lung Disease	☐ Depression	☐ Metal Implants
☐ Stroke/Seizure	☐ Thyroid Problems	☐ Panic Attacks	☐ Pregnant

11. Please check all of the following items that <u>currently</u> apply to you.

☐ Hearing Problem ☐ Visual Problems ☐ Recent weight loss ☐ Bowel or bladder control ☐ Smoker

12. Please list surgeries: _____
13. Please list allergies: _____
14. Please list medications you are currently taking: _____

_____

15. What goals do you want to achieve through your treatment at Evolve Physical Therapy + Advanced Wellness? _____

_____

16. How many fruits and vegetable do you eat per day? (1= your fist size): _____
17. Which of the following areas are you interested in improving? (Check all that apply)

☐ Energy	☐ Skin	☐ Decrease Inflammation	☐ Immune System
☐ Digestion	☐ Heart Health	☐ Mouth and Gum Health	☐ Sleep

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11468 Sorrento Valley Rd., Ste., A •San Diego, CA 92121 • P (858)457-3545 • F (858) 457-0976 • www.kgpt.com

PATIENT INFORMATION

☐ New Patient ☐ Returning Patient ☐ Current Patient

Referred By	Physician's Name	Date

Patient Name (Last, First, Initial)		Email Address		
Home Address		City	State	Zip
Home Phone	Work Phone	Ext.	Cell Phone	
Sex M F	Date of Birth	Last 4 of SS #		

Check the appropriate box:

☐ Work Related Injury ☐ Auto Accident ☐ Reoccuring Injury ☐ Other

☐ Private Injury ☐ Student Athletic Injury ☐ On-campus Injury ☐ Surgery

In case of emergency please notify:	Phone		Relationship
Address	City	State	Zip
If patient is a minor, name of responsible person	Phone of responsible person		

I hereby authorize Evolve Physical Therapy + Advanced Wellness to release any information acquired in the course of my evaluation or treatment for billing purposes.

_____
INITIAL

Signature of Patient or Responsible Party	Date

Go Green This original will be kept in your chart. A copy of this form is available upon request