Restor Physical Therapy
P.O. Box 8125
Fountain Valley, CA 92728-8125
Office: (714) 754.7268
Fax:(714) 434.7042

Patient Information

Please Print Clearly: **Today's Date:** ____________________

Patient's Name ____

Address ______________________________ City & State ______________ Zip __________

Social Security Number __________________ Sex: M F Date of Birth: __________

Employer __________________________ Occupation __________________

Employer Address __________________ City ______________ Zip ________

Best Phone Number to contact:

Primary ( ) __________________ Cell Home Work (circle one)

Secondary ( ) __________________ Cell Home Work (circle one)

Email: ____

Primary Physician / Referring Doctor ______________________________

How did you hear about us? (If other than Dr's referral) ______________________________

Are you under 18 and/or a dependent on a guardian's insurance? Yes No

If yes, Guardian's name ______________________________

Emergency Contact ______________________________ Phone ( ) __________________

Insurance/Billing Information

Please circle and fill out what is applicable

Private Insurance / Medicare

Please provide us a copy of your insurance card (s).

IF WORK OR AUTOMOBILE RELATED:

Insurance Company: ______________________________ CLAIM #: ______________________

Employer: ______________________________ Employer #: ( ) __________________

Date of Injury: ______________________

Adjuster Name: ______________________________ Adjuster #: ( ) __________________

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement, however, you are solely responsible for the remainder of any balances not paid by insurance.

You will be sent monthly statements, which will reflect any payments made by your insurance company on your behalf. Patient statements will be sent to the address given on page one- it is imperative that our office is notified of any address changes for either yourself or your insurance company so that proper follow up and collection efforts may be completed in a timely manner.

On the occasion of a missed appointment without notification, or notification with less than 24-hour notice before the scheduled appointment time, the patient is responsible for a $50 cancellation fee.

I agree to be financially responsible for all charges. I have read and understand this information.

Custom Physical Therapy applies a $30 returned check fee on the occasion that a payment is returned due to insufficient funds.

To Our Medicare Patients:
It is a requirement of Medicare that your physician / NPP review, date and sign a Plan of Care written by your therapist every 30 - 90 days to complete certification for initial and continued therapy. A physician/NPP may request the patient come in for an exam prior to certifying the Plan.

Assignment Of Benefits:
I hereby authorize payment directly to Custom Physical Therapy for Physical Therapy and/or Medical Benefits otherwise payable to me for services rendered.

Authorization To Release Information:
I hereby authorize Custom Physical Therapy to release any information required by my insurance company to process claims.

Patient Name (Print): ______________________ Date: ____________

Patient Signature: ______________________

Authorization For Treatment of a Minor:
If patient is under 18 years of age, authorization for physical therapy treatment is granted by a legal guardian of the patient by signing below.

Legal Guardian Name (Please Print) : ______________________

Legal Guardian Signature: ______________________

Relationship to Patient: ______________________

Restor Physical Therapy, Inc.
Patient History Report

Patients' chief complaint ____
____
____

Date of injury ________________________ Date of Surgery ______________
Date of most recent flare up ____
Mechanism of injury ____
This is a **New Injury/Old injury**
Past treatments for this condition consisted of ____________________________
____
These past treatments were **helpful/not helpful.**
What makes me feel better are ____
What makes me feel worse are ____
Activity make it feel **better/worse.**
Rest makes it feel **better/worse.**
Patient reports their current pain rating is _________________ (1 to 10 scale, 1 being best and 10 being worst)
Patient reports that their pain is **Sharp/Burning/Aching/Tingling/Numbness** or other ____
Patient reports their pain travels yes/no and if yes please describe where it travels to ____
Patient currently exercises Not at all/1 or 2 times per week/3 to 4 times per week/daily.
Patient has **had/not had** formal physical therapy for the above condition.
Patients current sitting tolerance is _________ minutes.
Patients current standing tolerance is _________ minutes.
Patients current walking tolerance is _________ minutes.

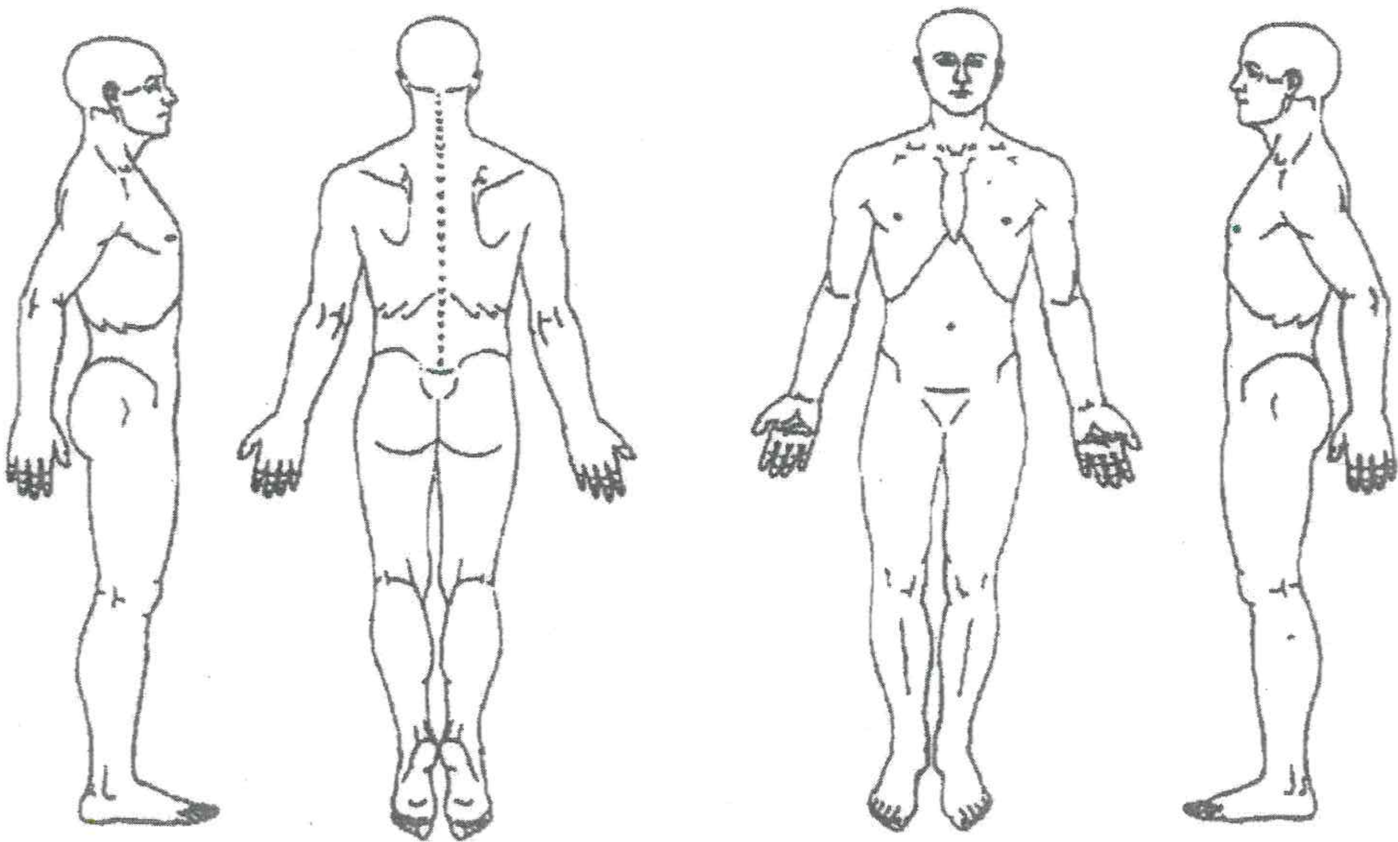
Body Chart: Please review the body chart on the following page and circle the areas where you have pain or discomfort and draw lines if the pain travels.

PAIN ASSESSMENT

Name: ______________________________ Date: ______________

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



Restor Physical Therapy

P.O. Box 8125
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Office: 714-754-7268
Fax: 714-434-7042

Consent to Treatment and Conditions of Treatment

Consent to Treatment: I ____

Consent to the procedures, which may perform during my treatment and care at **RESTOR PHYSICAL THERAPY,** including emergency treatment or services. These may include but are limited to therapeutic test, treatments and procedures, manipulation, stretching, or exercise treatment or procedures as directed under the general instructions of the Physical Therapist or Aide. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs relating to my physical condition as are deemed necessary.

Release of Information: **RESTOR PHYSICAL THERAPY** is authorized to release any information necessary, including copies of my Therapy and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer, or person otherwise responsible for payment to provide to **RESTOR PHYSICAL THERAPY** information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by the patient.

Financial Agreement/Assignment of Benefits: I assign any and all insurance benefits payable to me to **RESTOR PHYSICAL THERAPY**. I understand that I am responsible for payment of services rendered by **RESTOR PHYSICAL THERAPY** including excluded services from my insurance either because of the plans deemed such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney and/or collection expenses. I, the undersigned, state that the information that I have provided **RESTOR PHYSICAL THERAPY** is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement.

____ Date ____ ____________________
Signature of Patient or Representative

____ Date: ________________________
RESTOR Physical Therapy Representative

********************************PAYMENT POLICY***************************************
I authorize payment to be made and/or sent directly to Restor Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my Deductible and or Copayment upon each visit. I understand that verification of my insurance does not guarantee payment from My Insurance Company and that I will be responsible for payment to Restor Physical Therapy if Insurance denies payment.

Signature: ____ Date: ________________

Restor Physical Therapy Inc
P.O. Box 8125
Fountain Valley, Ca 92728-8125
Phone: 714-754-7268 Fax: 714+434-7042
HIPAA

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact Restor Physical Therapy Inc Office by mail or phone. Our contact information is listed above.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is **NOT** an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and

national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. 2 HIPAA Notice of Privacy Practices Revised 07/2022 Restor Physical Therapy, Inc P.O. Box 8125 Fountain Valley, Ca 92728-8125 714-754-7268

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information: You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees. You have the right to request a restriction of your protected health information – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You have the right to request to receive confidential communications – You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. You have the right to request an amendment to your protected health information – You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days. You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request. You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Patient Printed Name: ____________________________ Patient Signature: ___________________________

Relationship (if not patient): ______________________________ Date: ______________________________

Restor Physical Therapy, Inc.
Late Arrival Policy

Thank you for choosing Restor for your rehabilitation needs and for trusting us to contribute to your care and recovery. Our offices can get quite busy at times, and we work according to a very tight and structured schedule. Adhering to this schedule allows our therapists time to provide you with the care you need to maximize your recovery.

Showing up late to an appointment can adversely affect our schedule and will make it more difficult for our therapists to meet the demands of all their patients. Please read and understand the following guidelines and stipulations they will occur if you arrive late.

- We will do our best to get you seen and started on your therapy.
- Treatment tables may or may not be immediately available.
- We will not be able to perform manual therapy treatments.
- Your session will likely be more abbreviated.

I ____, have read and understand the information put forth in this document and my signature indicates that I accept Restor's policy regarding late arrivals. I understand that my full treatment is not guaranteed and Restor will try and accommodate me as time permits.

____   ________________
Signature   Date

____   ________________
Restor Representative   Date

Important and Updated COVID-19 Information

At Restor Physical Therapy, your health and safety come first during this unprecedented time. The department of Homeland Security and state governments have deemed physical therapy an essential component of health care during the COVID-19 pandemic. Therefore, our clinics remain open to serve those in need. We are taking extensive preventative measures, guided by the CDC, to protect our patients and employees who enter our clinics.

We hope that by providing this information, you can make a clear decision to continue you plan of care with us during this time. The following protocols are now in place:

Patient and Staff Screening: All patients and staff will be screened upon arrival for COVID-19 to make sure they are not exhibiting symptoms. Temperature checks will be administered as well. If a person presents with COVID-19 symptoms, they will be advised to return home and contact their physician. A 14-day quarantine will be mandated to reschedule for future appointments, unless a negative COVID-19 test can be provided prior to the 14 days.

Health Hygiene Protocols: On going reinforcement to all staff regarding hand washing and other preventative measures for equipment and supplies are in place and being reinforced.

Masking: In an effort to keep our patients and staff safe, anyone entering our center is required to wear a mask. If you have a medical condition or other restriction which prevents you from wearing a mask, please speak with the facility manager, Robin Wells. Per CDC recommendations, masks are essential when you are unable to avoid coming in contact with a person 6 feet apart. Our clinic provides treatment tables that are 6 feet apart. Also, patients performing cardio activity will be allowed to remove masks for their own safety.

Visitors: For patients coming to our facilities for care, we ask that you limit the number of people who accompany you to your appointments, unless they are necessary for transportation, translation services, and or assistance.

We strive to be as accommodating to all patrons to our facilities. However, if you do not feel comfortable coming to a facility for care during this time, we will gladly reschedule your appointment for a later date. In addition, many of our locations are now offering tele-rehab services so that you can easily connect with one of our licensed therapists through web-based technology that is HIPPA compliant.

Thank you for helping us ensure the safety of our patients and employees, as well as families of both. Please contact us if you have any questions or concerns.

Sincerely,
Restor Physical Therapy

Restor Physical Therapy Inc
Personal Protective Equipment Protocol

- All staff, patients, and visitors must wear masks upon entering the clinic. A patient will be able to remove mask during high level cardio or aquatic tasks
- Patients are to be scheduled in a manner where social distancing is maintained and adequate waiting room seating is provided
- All treatment tables must remain 6 feet apart and cleaned after every patient with appropriate cleaning solutions
- All equipment must be cleaned after each use, and placed in designated cleaning area until properly cleaned with cleaning solutions
- Our cleaning solutions include bleach and water and Simple Green Pro 3 Plus (antibacterial, virucide, and fungicide)
- All patients, visitors, and staff must be prescreened before starting their treatment sessions
- If a patient or staff has had any COVID-19 symptoms, been exposed to a COIVD-19 positive person, or has been out of the country within the last 2 weeks, a 14-day quarantine is mandated before scheduling future appointments, unless a negative COVID-19 test can be provided
- We have 3 hand sanitizing stations throughout the clinic available for all patients and staff
- All staff must wear gloves when handling equipment and or patient related tasks
- All staff must wash and or sanitize hands properly after coming in contact with equipment and or patients

NAME:____ **DATE**:____________

SIGNATURE: ____