HUMAN PERFORMANCE CENTER
PATIENT INFORMATION

Human Performance Center
REHABILITATION ◆ ACTIVE LIFESTYLE ◆ INJURY TREATMENT

Welcome! We appreciate your help in providing this information to complete your medical record.
We do not discriminate on the basis of race, age, color, sex, religion, handicap or nation origin.

OFFICE USE ONLY

Account Number _____ Appointment Time _____
Referring Dr. _____ Therapist _____ Account Type _____
Diagnosis _____ Authorized _____ Clerk _____

PATIENT INFORMATION

Name: _____
First *Middle* *Last*

Address: _____
Street Address *City* *Country* *Zip*

Phone (home) _____ Email _____
(work) _____ Date of Birth _____
(cell) _____ Social Security # _____

Sex ☐ Male ☐ Female

Preferred communication regarding appointments? ☐ Phone ☐ Text ☐ Email

Date of Injury/Surgery _____

How did you hear about us? ☐ Physician referral ☐ Yellow pages ad ☐ Other _____ ☐ HPC Website ☐ Friend

Insured's Name _____
First *Middle* *Last*

Address: _____
Street Address *City* *Country* *Zip*

Employer Address _____
Street Address *City* *Country* *Zip*

In case of an emergency, please notify: _____ *Name* _____ *Phone*

Is your injury/ illness Employment related? ☐ Yes ☐ No Auto Accident related? ☐ Yes ☐ No

Is there an attorney involved? _____ *Name* _____ *Phone*

PRIMARY INSURANCE

Name _____
Address _____
_____
Phone # _____
ID/ Group # _____
Insured's Social Sec # _____
Insured's Date of Birth _____

SECONDARY INSURANCE

Name _____
Address _____
_____
Phone # _____
ID/ Group # _____
Insured's Social Sec # _____
Insured's Date of Birth _____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, and CONSENT TO TREAT

I hereby authorize the Human Performance Center to release any information acquired in the course of my examination or treatment to my insurance company(s) or other medical providers who are participating in my care. I further authorize insurance benefits to be paid directly to the Human Performance Center. I agree to all the conditions listed in the financial policy I have read and signed. I consent to receive treatment at the Human Performance Center.

_____ *PATIENT SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS UNDER 18)* _____ *DATE*

BRIEF PATIENT HISTORY FORM

(FEDERAL REGULATIONS REQUIRE A MEDICAL HISTORY TO BE INCLUDED IN ALL PATIENTS MEDICAL RECORDS.)

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Name: _____ Date: _____
First Middle Last M / D / Y

1.What is the medical problem that brought you to us? _____
When approximately did this problem begin? Date _____
What was the cause? _____
Has it improved? ☐ Yes ☐ No Has it worsened? ☐ Yes ☐ No
What symptoms are you experiencing with this problem (circle all that pertain)

Swelling/Stiffness Loss of motion Fatigue Weakness
Numbness Tingling Ache/Pain Other _____

If you are experiencing pain, rate the level of pain you have had in the last 24 hours (please circle):

Pain scale: 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Worst

What does this keep you from doing? _____

2. Past Surgeries (please list, approximate date): _____

_____

3. Do you now have/or have you had any of the following:

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Back Pain	☐	☐
Chest Pain (Angina)	☐	☐	Arthritis	☐	☐
Heart Attack or Surgery	☐	☐	Osteoporosis	☐	☐
Angioplasty/Stent	☐	☐	Joint Replacement	☐	☐
Valvular Heart Problem	☐	☐	Parkinsonism	☐	☐
Congestive Heart Failure	☐	☐	Multiple Sclerosis	☐	☐
Pacemaker	☐	☐	Brain Injury	☐	☐
Arrhythmia	☐	☐	Dizziness	☐	☐
Diabetes	☐	☐	Balance Problems	☐	☐
Peripheral Vascular Disease	☐	☐	Hepatitis or HIV	☐	☐
Emphysema/Bronchitis/COPD	☐	☐	Epilepsy or Seizures	☐	☐
Asthma	☐	☐	Incontinence	☐	☐
Shortness of Breath	☐	☐	Pelvic Pain	☐	☐
Neuropathies	☐	☐	Visual impairments	☐	☐
Stroke, T.I A.	☐	☐	Hearing impairments	☐	☐
Cerebellar Problems (ataxia)	☐	☐	Inner ear problems	☐	☐
Difficulty Walking	☐	☐	Weight Gain/Loss	☐	☐
Anxiety	☐	☐	Changes in appetite	☐	☐
Depression	☐	☐	Hiatal Hernia	☐	☐
Sleep Disturbances	☐	☐	Allergies	☐	☐
Addictions	☐	☐	Cancer	☐	☐
Kidney Problems	☐	☐	Liver Problems	☐	☐

4. List your current prescribed medications: (or provide us with a list)

	Type	mg	Frequency		Type	mg	Frequency
a.				d.			
b.				e.			
c.				f.			

4. Physical problems can affect our emotional wellbeing. HPC offers consultation by a Social Worker or counselor to provide social and emotional support. Would you be interested in an initial consultation?

☐ Yes ☐ No ☐ Maybe

5. Appropriate nutrition contributes to your overall health and wellbeing. Would you be interested in meeting with our dietician/nutritionist to assist you with any of the following:

☐ Making wise food choices ☐ Managing your weight ☐ Diabetic management ☐ Other _____

_____ _____
SIGNATURE DATE

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SELF PAYMENT OF SERVICES

In this day of high insurance deductibles, you can call us for an appointment, receive immediate evaluation and treatment, and pay us directly. You will receive one on one care and hands on services for up to one hour by a physical therapist. Payment for these services is due at the time of service. HPC will not bill my insurance for these services.

You may ask "can I submit my bills to my insurance for reimbursement?" The answer in most cases is yes. We will provide you with a super-bill which will include the codes and charges for our services. Although California allows physical therapists to provide services without a physician referral, your insurance may require a referral and if so you would have to obtain one and submit it along with our super-bill to obtain reimbursement. We would advise you to inquire from your insurance company as to their policy.

INSURANCE BILLING:

The Human Performance Center accepts most insurances. We will check with your insurance plan relative to physical therapy benefits including deductibles, co-insurance portions and limit on the number of visits. You are responsible for any co-payments, co-insurance, unpaid deductible amounts or services not covered by your insurance.

In order to bill your insurance we request that you provide us with
1. Current insurance card
2. If your insurance requires it, a referral from your medical provider.

SPECIAL NEEDS:

We understand special situations may arise. Patients with financial problems or special needs should speak to our office manager as soon as possible. If appropriate, special arrangements can be made and a payment plan established.

THE IMPORTANCE OF REGULAR APPOINTMENTS:

Optimal progress is achieved by regular adherence to the appointments and home instructions. Please notify us **24 hours in advance** if you are unable to keep your appointment so that we can schedule another patient in your place. Failure to show for a scheduled appointment may result in a $40.00 charge that must be paid at the next appointment time.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT:

- I agree to pay any co-payments and/or co-insurance and portions of my yearly deductible not yet met.
- If it is determined I am not eligible for benefits under my insurance plan, I agree to pay the balance in full.
- I have read the above and agree to these policies.

_____ _____

PATIENT SIGNATURE *DATE*

HUMAN PERFORMANCE CENTER
COMPLIANCE PROGRAM PRIVACY AND SECURITY COMPLIANCE PLAN PRIVACY & SECURITY NOTICE

Human Performance Center, in compliance with certain laws, has taken reasonable and comprehensive steps towards the protection of the privacy and security of your personal health information. Such information may include oral, written, telephone, facsimile and/or other electronic communication of protected health information (PHI).
Complete information regarding Privacy and Security Practices is available to all patients upon individual request and such information is entitled "*Statement of Privacy and Security Practices"*.
Individual Patient Rights: You have rights with respect to the following:

- To read and understand this privacy and security notice prior to treatment
- To request a copy of "Statement of Privacy and Security Practices"
- To expect that all protected health information be utilized only for the following purposes:
  - Treatment (including contacting you with regards to appointment and other treatment related communication)
  - Payment
  - Health Care operations
  - Mailing or other communication with you in the form of announcements and/or newsletters
- To request a copy of your personal health information
- To request revision of inaccuracies in your personal health information
- To restrict how your personal health information is used and disclosed except as noted above

Further Information/Concerns: Please express any concerns you may have regarding any violation of your privacy rights, and other privacy and security issues to Human Performance Center Compliance Officer:

Robert R. Huhn

805-687-8553

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RECEIPT OF PRIVACY & SECURITY NOTICE

I, _____ , hereby acknowledge that I have received the Privacy & Security Notice from the Human Performance Center, as per HIPAA regulations. I also understand that I may request a complete copy of the "Statement of Privacy and Security Practicies".

_____

Patient Signature

_____

Print Name

_____

Date