

# WOMEN'S ADVANTAGE PHYSICAL THERAPY

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Appointment Time: \_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Account #: \_\_\_\_\_

## PATIENT INFORMATION

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  Male  Female

Name:(Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Suffix/nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_ or  Retired  Full-time Student  Part-time Student

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

Occupation: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Work Email Address: \_\_\_\_\_ Home Email Address: \_\_\_\_\_

## FOR OFFICE USE ONLY

Location: \_\_\_\_\_ Referring Physician or Profile #: \_\_\_\_\_ UPIN# \_\_\_\_\_

Physician Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Physician Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_ Services Ordered:  PT  OT  Both Body Part: \_\_\_\_\_

Prescription Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ #Visits Ordered: \_\_\_\_ Specific Orders: \_\_\_\_\_

Diagnosis Code (s): \_\_\_\_\_ Service Class: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relation to Patient:  Self  Spouse  Parent  Other

Insured's Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Employer: \_\_\_\_\_ or  Retired  Full-time Student  Part-time Student

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

## ACCIDENT / INJURY / ONSET - INFORMATION

Previous Surgery for This Body Part?  Yes  No Acc/Injury/Onset Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (exact date of injury for Auto or Work)

Accident Type :  Work  Auto  Other  None (accident due to other than Auto or Work)

Accident Details: \_\_\_\_\_

**If Accident – include where and how accident occurred / If Non-Accident – include reason for visit.**

If Accident, enter State where accident occurred? \_\_\_\_\_ WC only – Will add. auth be required for add. body part/time:  Yes  No

## PAYOR INFORMATION

Verification Phone #(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Payor Name: \_\_\_\_\_ Profile # \_\_\_\_\_ Claim Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext: \_\_\_\_\_

Policy/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Plan associated with IPA  Yes  No IPA Name: \_\_\_\_\_

Secondary Ins?  Yes  No

## FOR OFFICE USE ONLY

Secondary Ins. Name \_\_\_\_\_

Secondary Policy #: \_\_\_\_\_ Secondary Verification Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Patient Signature (certifying that all personal information on this form is correct): \_\_\_\_\_ Date: \_\_\_\_\_

*Women's Advantage Inc.*

**Patient Name:** \_\_\_\_\_ **MD:** \_\_\_\_\_  
**DX:** \_\_\_\_\_ **MR#:** \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Check/Circle all that apply)

**VOICE COMMUNICATION**

HOME # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_ OTHER # \_\_\_\_\_

Ok to leave message with detailed information: Home / Work / Cell / Other

Leave message with call back number only : Home / Work / Cell / Other

The following people are authorized to receive my medical information:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**WRITTEN COMMUNICATION**

OK to mail to home address

OK to mail to work/office address

OK to mail to a different address: \_\_\_\_\_

Home fax: (\_\_\_\_) \_\_\_\_\_

Work Fax: (\_\_\_\_) \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.... Healthcare entities must keep records of PHI disclosures.

I have received Women's Advantage, Notice of Privacy that provides a more complete description of information uses and disclosures, I understand that it may become necessary to disclose my PHI to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the Notice of Privacies Policies. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information to revoke this consent by following the procedures outlined in the Notice of Privacy Policies. However, Women's Advantage is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Notes: Uses and disclosure for treatment, payment, operations (TPO) information may be permitted without prior consent in an emergency.

Signature of Patient/Parent/Guardian

Date

Print Name

Name of Patient (if different)

Women's Advantage 20911 Earl Street, Suite 300, Torrance, CA 90503

Phone (310) 370-1200 Fax (310) 370-1233 WWW.womens-advantage.com



### Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to

*WOMEN'S ADVANTAGE Inc.*

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS:

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Estimated patient payment \_\_\_\_\_

Note: Estimated coverage information is provided as a courtesy to our patients.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature



*Women's  
Advantage Inc.*

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent for

*WOMEN'S ADVANTAGE INC.*

to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Benefit Assignment/Release of Information**

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to

*WOMEN'S ADVANTAGE INC.*

A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_



## **WOMEN'S ADVANTAGE INC.**

### **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 IT CAREFULLY.

### **WOMEN'S ADVANTAGE INC. LEGAL DUTY**

WOMEN'S ADVANTAGE INC. 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, WOMEN'S ADVANTAGE INC. 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.

WOMEN'S ADVANTAGE INC. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, WOMEN'S ADVANTAGE INC. 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 further disclosures at any time.

WOMEN'S ADVANTAGE INC. 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 an updated 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 not 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. WOMEN'S ADVANTAGE INC. 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 WOMEN'S ADVANTAGE INC. 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 practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on WOMEN'S ADVANTAGE INC. health information practices, or if you have a complaint, please contact the following person:

WOMEN'S ADVANTAGE INC.  
20911 Earl Street, Suite 300  
Torrance, CA 90503



**WOMEN'S ADVANTAGE INC.**

**PATIENT INFORMATION ACKNOWLEDGEMENT FORM**

I have read and fully understand WOMEN'S ADVANTAGE INC. Notice of Information Practices. I understand that WOMEN'S ADVANTAGE INC. 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 WOMEN'S ADVANTAGE INC. 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 WOMEN'S ADVANTAGE INC. Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent/Guardian  
(if patient is a minor)

\_\_\_\_\_  
Date

*(OPTIONAL)*

I also authorize WOMEN'S ADVANTAGE INC. to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent/Guardian  
(if patient is a minor)

\_\_\_\_\_  
Date



## **To Our Patients Regarding Cancellations and No-Shows And Other Financial Concerns**

The following are our policies regarding cancellations and no-shows. We take this subject seriously at our clinic because coming consistently to physical therapy can make the difference between whether you succeed in your treatment or not. Usually your physical therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits are very important. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24-hour notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternate time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a \$25.00 charge for a cancellation without a 24-hour notice. There is a \$35.00 charge for cancellations with less than a 6-hour notice. Without enough notice for cancellations, we are not able to fill that spot with another patient who would like to come off our waiting list.
- There is a \$45.00 charge for not showing up for your appointment with failure to give us any notice.
- These charges are not covered by your insurance but will have to be paid by you personally prior to your next visit with your therapist. These charges need to be paid by cash or check made out to Women's Advantage Inc.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist at the next regularly scheduled visit.
- Your co-payment, or estimated co-insurance payment, is due the day of your treatment. If that fee is not paid at the time of treatment, a \$5.00 late fee will be added to the total.

Thank you for your cooperation and understanding with these policies. This allows our therapists to be able to care for as many patients as their schedule allows and assists you to get the full benefit of your physical therapy. We look forward to working with you.

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Patient Name

Patient Signature

Date



To Patients of Women's Advantage Inc.:

In the evaluation and treatment of a majority of our patients, we use modalities such as biofeedback and/or electrical stimulation. These modalities require either external or internal sensors for the pelvic floor muscles. These sensors are not covered by insurance and need to be purchased by the patient. The cost of the external sensors is \$12 and the internal sensor is \$50. During the evaluation, your therapist will determine which sensor you need. You will need to pay for the sensor at the end of your first visit. Please make the check payable to Women's Advantage, Inc.

If you have any questions, please ask your physical therapist.

Thanks!

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Patient Signature

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Date

Patient's Name:

Medicare # (HICN):

## ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE:** You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

**Items or Services:**

Biofeedback sensors: \$12.00 or \$50.00 depending on type of sensor.

Theraband: \$5.00

\*Cancellation <24 hrs advanced/Late cancel <6 hrs advanced/No show: \$25.00/\$35.00/\$45.00

**Because:**

Pelvic Floor Strengthening and re-education with biofeedback

\*Women's Advantage PT's policy and procedure

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ \_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

**Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_



**Women's Advantage Physical Therapy**

20911 Earl Street, Suite 300  
Torrance, CA 90505  
(310) 370-1200 Fax (310) 370-1233

**Medical History**

Please provide your detailed medical history by filling out this form. This is a requirement by Medicare for us to keep a detailed record of your health history.

**Personal History**

Please check <input checked="" type="checkbox"/>	Yes	No
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder dysfunction .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia or emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>

Please check <input checked="" type="checkbox"/>	Yes	No
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Hernia .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid dysfunction.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital abnormalities .....	<input type="checkbox"/>	<input type="checkbox"/>
Surgical implants .....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please list all surgeries, invasive medical procedures, fractures and other serious injuries. Include approximate date and any lasting complications or disabilities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list present medications that you are taking:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to the following?

Please check <input checked="" type="checkbox"/>	Yes	No
Novocaine / Lidocain	<input type="checkbox"/>	<input type="checkbox"/>
Iodine compounds	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list): _____		

Your weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Family History**

Has any immediate family relative ever had any of the following:

Please check <input checked="" type="checkbox"/>	Yes	No
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>

Please check <input checked="" type="checkbox"/>	Yes	No
Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder dysfunction .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>

I certify that this information is correct and true: X \_\_\_\_\_ / /  
Signature date

