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42301 10<sup>th</sup> St. W., Lancaster, CA 93534 P:(661)942-2202 F:(661)942-2203

Dear Patient,

We are pleased that you have chosen Young Physical Therapy, Inc. Specialty Center for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:

- Completed forms
- Insurance card(s)
- Prescription for physical therapy with diagnosis

Please arrive **5-10 minutes early** to allow sufficient time for check-in if completed all forms, otherwise please come 30 minutes early to fill out all forms.

Sincerely,

Young Physical Therapy, Inc. Specialty Center



# Patient Registration Form

\*\*\* Please present your ID and Insurance card(s) for copying\*\*\*

Patient Name:		Date of Birth:	Age:	Sex: M / F
Address:		City, State, Zip		
Drivers License#:	Social Security Number:	E-mail Address:		
Home Phone: ( ) - OK to leave message? Yes / No	Work Phone: ( ) - OK to leave message? Yes / No	Cell Phone: ( ) - OK to leave message? Yes / No		
Marital Status: Married / Single / Divorced / Separated / Widowed		Student: No / Full-time / Part-time		
Employer:	Employment: Full / Part-time / Not working / Retired			
Emergency Contact:	Relationship:	Emergency Contact phone:		
Financial Party: (if other than patient)	Relationship:	Social Security Number:	Date of Birth:	
Home Phone:	Work Phone:	Employer:		
Referring Physician:	Primary Physician:			
How did you hear about Young Physical Therapy, Inc. Specialty Center?				

## CANCELLATION POLICY and CONSENT to TREAT

We at Young Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. If any established patient who fails to show or cancel at least 24 hours before the scheduled appointment, a **\$20 no show/cancellation fee** charge will be billed directly to the patient for each cancellation. Also, if a **third no show or cancellation with no 24 hour notice** occurs, then the patient may be **dismissed** from Young Physical Therapy.

**By signing below, you acknowledge that you have read, understood and agree to abide by our no show/cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.**

I grant permission for the staff of Young Physical Therapy, Inc. Specialty Center to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicates that I understand and give consent to be treated as explained above.**

Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:
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## Appointment Cancellation No show Policy

We at Young Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment.

This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective September 15, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **\$20.00 fee**.
- If a **second** No Show or cancellation/reschedule with no 24-hour notice occur, **all future scheduled appointments will be removed** until a show/cancellation fee is made
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Young Physical Therapy.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. Even if you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office, we may be able to waive the No Show fee. You may contact Young Physical Therapy 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

**Young Physical Therapy, Inc. Specialty Center (661) 942-2202**

**I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.**

<b>Patient Signature:</b>	<b>Guardian's Signature:</b> (If patient is <18 years old)	<b>Date:</b>
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## Office Payment Policy

It is the policy of Young Physical Therapy, Inc. Specialty Center that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their **deductible, co-pay** and/or **co-insurance** payment at the beginning of each visit.

**Deductible-** is the contracted rate that you have with your insurance that needs to be met before your benefits become effective. Insurances often apply your deductible to your visits. When this happens, **please understand** that we (Young Physical Therapy, Inc.) do not get paid anything from the insurances; they are requiring that you pay us. The Front office at your location will explain this information to you prior to your first visit. At the conclusion of your therapy with Young Physical Therapy, Inc. Specialty Center you may be billed for any outstanding balances. If there is a positive balance or credit, you will be provided a refund promptly.

**Co-payment-** is a flat rate that you have contracted with your insurance.

**Co-Insurance-** is a certain percentage of the visit that you are required to pay for. We provide you with **estimated** dollar amount. This amount is never guaranteed, we are only given the exact amount when we receive the claim.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with our billing department before starting your treatments.

**Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:**

\_\_\_\_\_ 1. **PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, co-pay, and co-insurances, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

\_\_\_\_\_ 2. **MEDICARE:** Young Physical Therapy, Inc. is a certified Medicare provider. Medicare Supplement insurance (secondary insurance) covers the patient portion due until your Medicare benefits are exhausted. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

\_\_\_\_\_ 3. **Secondary Medicare Insurance Provider:** \_\_\_\_\_

\_\_\_\_\_ 4. **NO INSURANCE (CASH):** If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

\_\_\_\_\_ 5. **WORKER'S COMPENSATION CLAIMS:** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the front office with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

\_\_\_\_\_ 6. **HEALTH MAINTENANCE ORGANIZATION (HMO):** Insurance plans require authorization from your medical group. Most insurance plans have a patient responsibility (co-pay). Co-pay is due at the time of service. Should your insurance deny coverage, we will bill you for the outstanding amount.

\_\_\_\_\_ 7. **OTHER:** Please list the other type of payment: \_\_\_\_\_

**I have reviewed this office payment policy and discussed it with the front office. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.**

<b>Patient Signature:</b>	<b>Guardian's Signature:</b> (If patient is <18 years old)	<b>Date:</b>
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## Protecting Your Medical Identity

Most people are aware of the risk of identity theft related to financial records, social security numbers, etc. As a recipient of healthcare services, you also need to be aware of the risk of other people using your identity to obtain medical services under your insurance coverage. Medical Identity Theft is a real risk in our society and the consequences can be very serious. For example, if a person uses your identity to obtain services, your medical record may be compromised by the other person receiving treatment for illnesses that would be contradictory to your health history.

Due to these risks, we take precautions to help protect your medical identity. This includes requiring our admissions staff to require that you show a photo identification at the point of admission or at the point of your first visit. Please be understanding of our staff when they ask you for ID, as it is part of the process to help protect your Medical Identity. You should also be proactive in guarding and protecting your insurance card number, Medicare number, and Social Security number.

You should be aware and watch for the following Red Flags as possible signs of Medical Identity Theft. If you become aware of any of these areas of concern, please let us know so we can assist you in making any necessary corrections and notifications of appropriate government agencies. We also encourage you to contact the Federal Trade Commission at 877-FTC-HELP to report any issues.

- You receive a bill or a notice of insurance benefits (Explanation of Benefits EOB) for services you did not receive.
- You receive a collection notice from a bill collector for a bill that you think does not relate to services you received.
- You notice information added to your credit report by a healthcare provider or insurer.
- You receive an inquiry from an insurance fraud investigator or a law enforcement agency.

If you have any questions related to Medical Identity Theft, you may call our Compliance Officer at (661)942-2202.

**\*\*\*Please retain this copy for your records\*\*\***



# CONSENT & ASSIGNMENT FORM

Please read before signing

**\*\*\*\*Medical Records Release Authorization\*\*\*\***

I hereby authorize Young Physical Therapy Inc. to copy and transmit to the person(s) named below any and all medical records whatsoever, pertaining to my treatment by Young Physical Therapy Inc.  
Persons to whom the records may be released:

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

**\*\*\*\*Authorization for the Treatment of Minors\*\*\*\***

I hereby authorize Young Physical Therapy Inc. to perform Physical or Occupational Therapy or Speech Therapy on the minor named \_\_\_\_\_ of the parent or guardian named herein \_\_\_\_\_.

**\*\*\*\*Medicare Authorization\*\*\*\***

I certify that the information given by me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf.

**\*\*\*\*Managed Care\*\*\*\***

I understand that, without an authorization/referral from my medical group etc., I will be financially responsible for charges I incur.

**\*\*\*\*Attorney Payment Authorization\*\*\*\***

I authorize and direct my attorney to deduct from the proceeds of my recovery from a third party, as a result of injuries sustained by me, such amounts necessary to pay Young Physical Therapy Inc. and satisfy their total bill. I further authorize and direct my attorney to pay the sum directly to Young Physical Therapy Inc. at the time of receipt of compensatory monies from a third party. I understand that I remain personally liable for payment of the total bill for professional services rendered to me and for related medical expenses, even if a settlement of judgment is not obtained.

**\*\*\*\*Financial Policy\*\*\*\***

I certify that the information provided is correct. I understand that I am personally responsible to pay all charges for services rendered to me. I authorize payment for these services to be paid directly to Young Physical Therapy Inc.

We must emphasize that as providers, our relationship is with you. *Your insurance is a contract between you, your employer and the insurance company.*

We realize that temporary financial difficulties may affect timely payment of your account. If such problems do arise, we encourage you to contact us immediately for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you.

\_\_\_\_\_  
X Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

[Young Physical Therapy, Inc. 42301 10<sup>th</sup> St. W. Lancaster, CA 93534]

[Privacy Officer :Younghoon Kim, PT,DPT,OCS,CSCS Phone#:(661)942-2202 ]

**Effective Date:** September 23, 2013

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.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

### **A. How This Medical Practice May Use or Disclose Your Health Information**

This medical practice collects health information about you and stores it in a chart / personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
14. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
15. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
18. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]
19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

## **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this physical therapy practice, except that this physical therapy practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 15 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

#### **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

U.S. Department of Health & Human Services  
90 7<sup>th</sup> Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437-8310; (415) 437-8311 (TDD)  
(415) 437-8329 FAX **OCRMail@hhs.gov**

The complaint form may be found at **[www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)**. You will not be penalized in any way for filing a complaint.

**\*\*\*Please retain this copy for your records\*\*\***



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**Acknowledgement of Receipt of Privacy Notice  
in Combination with Voluntary Consent Acknowledgement**

As a patient of Young Physical Therapy Inc. I have been provided with its **Notice of Privacy Practices** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of Young Physical Therapy, and my rights to privacy protection and access to my medical information.

**Consent:**

I give consent for medical information about me to be used and disclosed for the purposes of treatment, payment or health care operations. I understand that the privacy regulations allow Young Physical Therapy to use or disclose my medical information for these purposes and that my consent is not required. Young Physical Therapy is obtaining my consent to provide additional assurances regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Young Physical Therapy may choose not to agree to the request for a restriction of the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

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Signature of Patient or Personal Representative

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Date

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Printed Name of Patient or Personal Representative

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Description of Personal Representative's authority to act on Patient's Behalf



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Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Young Physical Therapy Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Young Physical Therapy Inc. to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be valid as an original.

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Young Physical Therapy Inc. and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered in this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

Young Physical Therapy Inc.  
42301 10<sup>th</sup> St W  
Lancaster, CA 93534

Financial Responsibilities

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting money owed. I further understand, and agree to follow the fee payment listed below, along with a \$10 fee for late or skipped payments.

**Amount Outstanding**

\$ 1-50  
\$50-199  
\$200-399  
\$400 +

**Minimum Amount Due**

Balance in full  
\$50 per month  
\$75 per month  
\$100 per month

*I have read and fully understand all of the above information and hereby agree to comply as outlined above.*

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Guardian Signature



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Due to Federal Law (US Code 42, Chapter 7, Subchapter XI, Part A, § 1320a-7b, the Anti-Kickback Act, and HIPAA of 1996) and State Law,

It is “**Healthcare Fraud**” for medical providers to **write-off** patient **co-pay** and **deductibles** under any public or private health benefit plan.

Please be prepared to pay your portion at the time of service

**\*\*\*Please retain this copy for your records\*\*\***



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## Payment Agreement

Due to Federal Law(US Code 42, Chapter 7, Subchapter XI, Part A, § 1320a-7b, the Anti-Kickback Act, and HIPAA of 1996) and State Law,

It is “**Healthcare Fraud**” for medical providers to **write-off** patient **co-pay** and **deductibles** under any public or private health benefit plan.

Please be prepared to pay your portion at the time of service

*We estimate your portion to be \$\_\_\_\_\_ per each visit.*

*We will refund you any over payment and in the event there is a balance on your account, you will be billed at the end of you treatment.*

Patient/Parent Signature:\_\_\_\_\_ Date::\_\_\_\_\_



## MEDICAL HISTORY QUESTIONNAIRE

*Your responses to the following questions will assist us in your treatment.*

*Thank you for your cooperation.*

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Primary Language \_\_\_\_\_

### Demographics

**Medical History: Have you ever been diagnosed with any of the following problems?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> No Known Significant medical          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> Alzheimer's                           | <input type="checkbox"/> History Of Cancer   | <input type="checkbox"/> Traumatic Brain Injury    |
| <input type="checkbox"/> Cardiovascular Disease                | <input type="checkbox"/> Huntington's        | <input type="checkbox"/> Other (description below) |
| <input type="checkbox"/> Cauda Equina Syndrome                 | <input type="checkbox"/> Immunosuppression   | _____  |
| <input type="checkbox"/> Cerebral Vascular Accident            | <input type="checkbox"/> Lupus               | _____  |
| <input type="checkbox"/> Current Infection                     | <input type="checkbox"/> Muscular Dystrophy  | _____  |
| <input type="checkbox"/> Diabetes Mellitus ( Type 1 / Type 2 ) | <input type="checkbox"/> Obesity             | _____  |
| <input type="checkbox"/> Fibromyalgia                          | <input type="checkbox"/> Osteoarthritis      | _____  |
| <input type="checkbox"/> Fracture Or Suspected Fracture        | <input type="checkbox"/> Parkinson's         | _____  |

**Medication: Are you taking any medication(prescribed/over the counter)?** \_\_\_\_ Yes, \_\_\_\_ No If yes, please specify

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

**Surgery History: Please list any hospitalizations or surgeries you have had.**

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

**For what reason have you been referred to therapy?**

\_\_\_\_\_

**What is your goal for therapy to accomplish?**

\_\_\_\_\_

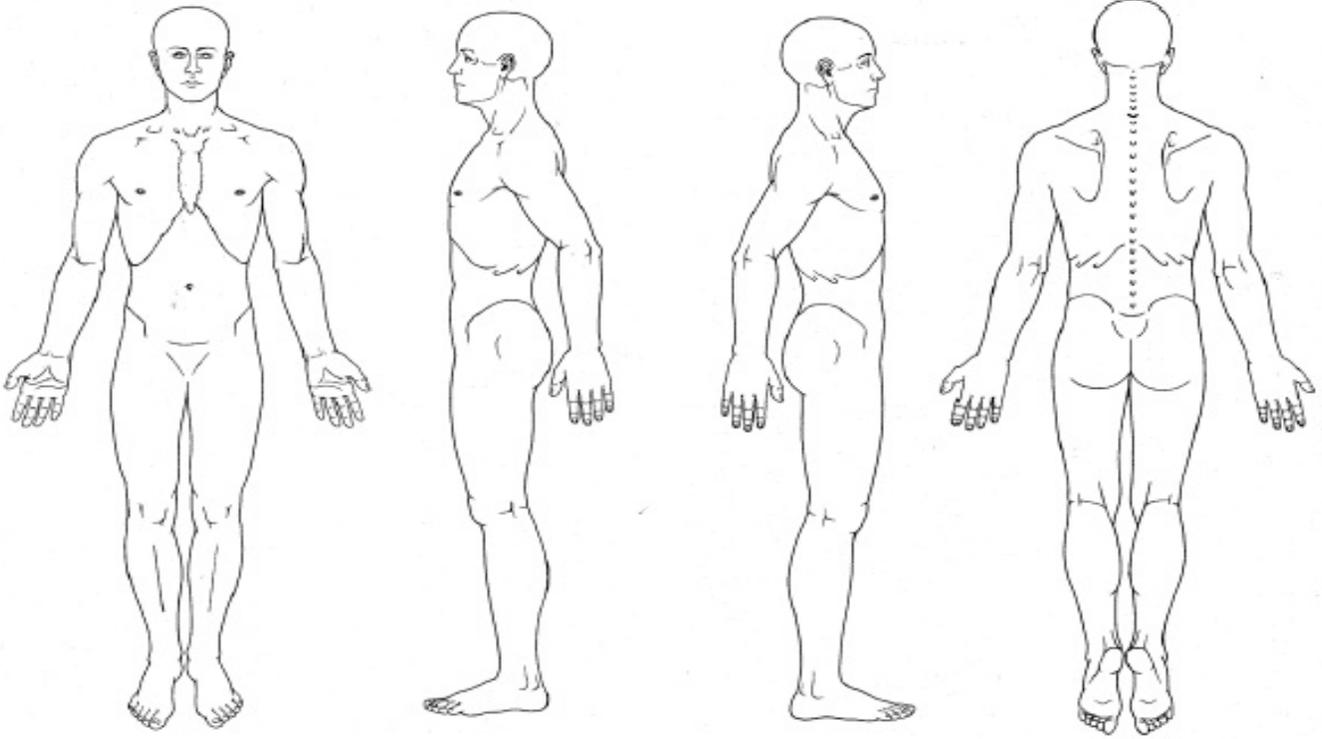
**Additional Comments or Concerns**

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

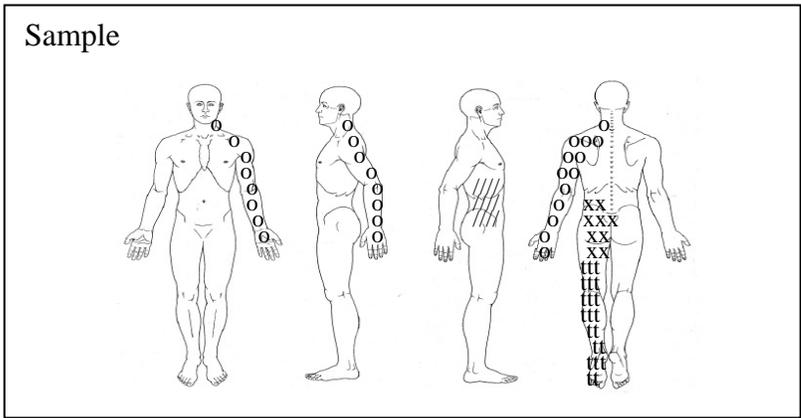
*Please sign a date as a verification of the above information*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

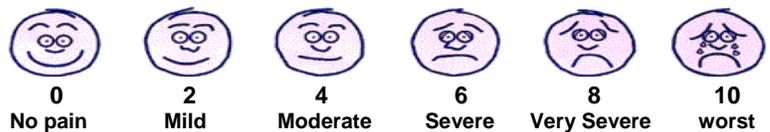
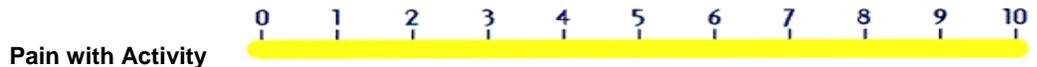
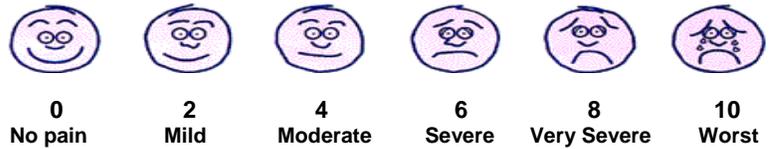
# Whole Body Symptom Description



Symptom Key	
<b>0000</b>	Numbness
<b>tttttt</b>	Tingling
<b>xxxxxx</b>	Burning
<b>//////</b>	Stabbing
<b>=====</b>	Aching
<b>cccccc</b>	Cramping
<b>sssss</b>	Sensitive
<b>pppp</b>	Other



Please place a vertical mark on the line below to indicate the severity of your complaint.



Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_