WOMEN'S ADVANTAGE
MEN'S OPTIMAL HEALTH
specialized pelvic physical therapy

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:___ Date of Birth: _____/_____/_____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Home Email: _____ Work Email: _____

Please check if you would like to receive: ☐ E-mail Appointment Reminders ☐ E-Newsletter

Referring Physician: _____ Physician's Phone: (_____) _____

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 all that apply.)*

By phone at: ☐ Home ☐ Work ☐ Cell ☐ Other: (____) _____

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

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

In writing to: ☐ Home Fax: (____) _____ ☐ Work Fax: (____) _____

☐ Home Address ☐ Work/Office Address ☐ Different address: _____

The following people are authorized to receive my medical information. (It is NOT necessary to list your referring physician(s).)

Name: _____ Phone: (_____)_____ Relationship: _____

Name: _____ Phone: (_____)_____ Relationship: _____

Name: _____ Phone: (_____)_____ Relationship: _____

CONSENT FOR CARE AND TREATMENT

I hereby give my consent to **Women's Advantage Inc.** to furnish the appropriate and necessary medical care needed to diagnose and treat the physical and mental condition of the above named patient.

_____ _____

Patient OR Patient Guardian's Signature Date

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FINANCIAL POLICY

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. Should your insurance company request a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Women's Advantage Inc. You also agree to assign all medical and/or surgical benefits to which you are entitled, including Medicare, Medicaid, private insurance and third party payors to Women's Advantage Inc.

Estimated coverage information is provided as a courtesy to you. **Please realize this is only a good faith payment toward your final bill. This is not payment in full.** If you have a deductible and/or co-insurance, we will collect towards the patient portion responsibility which is an approximate amount. You may be billed for an additional amount once your claim has been processed. There will be a $20.00 service fee for all returned checks.

If you fail to make any of the payment for which you are responsible in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

CANCELLATION POLICY

Your cooperation with the following policies will enable our therapists to care for as many patients as their schedule allows and will assist you in getting the full benefit from your physical therapy.

- We require 24 hour cancellation notice.
- You will be charged $40.00 for a cancellation without at least 24 hours' notice.
- You will be charged $50.00 for not showing up for your appointment with failure to give any notice.
- These charges are not covered by your insurance. You will have to pay for them prior to your next visit with your therapist.

EXTERNAL / INTERNAL SENSOR POLICY

In the evaluation and treatment of the majority of our patients, we use modalities such as biofeedback and/or electrical stimulation which require either external or internal sensors for the pelvic floor muscles. During your evaluation, your therapist will determine if your treatment will require the use of sensors. These sensors are not covered by insurance and need to be paid for by the patient upon receipt. The external sensor fee is $13.00 and the internal sensor fees range from $30.00 to $53.50. These charges are one time flat fees.

I have read and agree to comply with all of the policies outlined above. I understand my responsibility for the payment of my account.

_____ _____

Patient OR Patient Guardian's Signature Date

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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:

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

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

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

_____
Patient Name

_____ _____
Patient OR Patient Guardian's Signature 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

_____ _____
Patient OR Patient Guardian's Signature Date

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MEDICAL HISTORY

Please provide your detailed medical history by filling out this form. Medicare requires that we keep a detailed record of your health history.

Personal History

Please check ✓	Yes	No	Please check ✓	Yes	No
Heart disease	☐	☐	Tuberculosis	☐	☐
Heart attack	☐	☐	Asthma	☐	☐
Rheumatic fever	☐	☐	Hepatitis	☐	☐
High blood pressure	☐	☐	Anemia	☐	☐
Stroke	☐	☐	Bleeding disorder	☐	☐
Epilepsy	☐	☐	Hernia	☐	☐
Kidney or bladder dysfunction	☐	☐	Thyroid dysfunction	☐	☐
Diabetes	☐	☐	Congenital abnormalities	☐	☐
Cancer	☐	☐	Surgical implants	☐	☐
Respiratory disease	☐	☐	Pacemaker	☐	☐
Pneumonia or emphysema	☐	☐	Are you pregnant?	☐	☐

Do you currently have an intrauterine device (IUD) implanted? ☐ ☐

Do you have any history of or current sexually transmitted disease (ex. Herpes, HPV, chlamydia, etc.)? ☐ ☐

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, including the dosage and frequency:

_____

_____

Do you have any allergies to the following?

Please check ✓	Yes	No
Novocaine / Lidocaine	☐	☐
Iodine compounds	☐	☐

Other (please list):_____

Your weight:_____ Height:_____

Have you received physical therapy at another clinic?

☐ Yes, currently. ☐ Yes, in the past. ☐ No

If yes, for which body part? _____

Family History - Has any immediate family relative ever had any of the following:

Please check ✓	Yes	No	Please check ✓	Yes	No
Heart disease	☐	☐	Epilepsy	☐	☐
Heart Attack	☐	☐	Kidney or bladder dysfunction	☐	☐
Rheumatic fever	☐	☐	Diabetes	☐	☐
High blood pressure	☐	☐	Cancer	☐	☐
Stroke	☐	☐			

I certify that this information is correct and true.

NAME: (please print)_____

SIGNATURE: _____ DATE:_____

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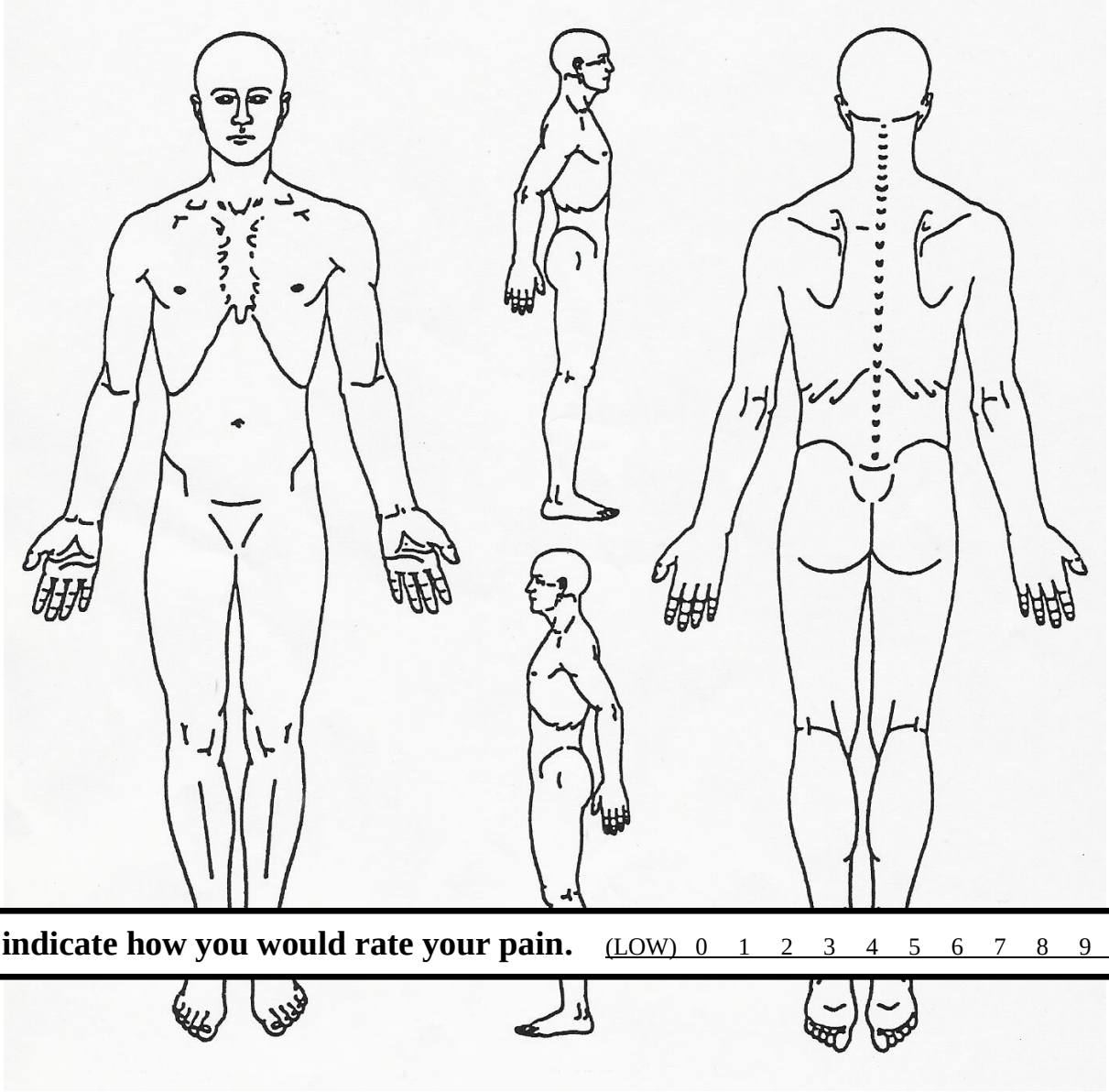
PAIN SCALE

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain. (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)_____

SIGNATURE: _____ DATE:_____

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