



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: (____) _____

Email Address

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



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



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 48 hour cancellation notice for new evals; 24 hours for follow ups.
- ◆ Due to a high volume of patients scheduled on a daily basis, patients are expected to be on time for their appointments. When patients are late, it greatly impacts the care of other patients. Patients will be allowed a **15-minute grace period**; otherwise late patients will be rescheduled and charged.
- ◆ You will be charged \$42.00 for a cancellation without at least 24 hour notice.
- ◆ You will be charged \$52.00 for not showing up for your appointment with failure to give any notice.
- ◆ These charges are not covered by your insurance. **The fees will be applied to your credit card on the same day of cancelled and no showed appointments.**

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 \$14.00 and the internal sensor fees range from \$30.00 to \$55.50. 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



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



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



Patient Name:

Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for item(s) or service(s) listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the item(s) or service(s) listed below.

Items or Services:	Reason Medicare May Not Pay:	Estimated Cost
Biofeedback sensors	These supplies are not a covered benefit, but they are essential for muscular re-education, improving pelvic stabilier strength, and decreasing pain and inflammation.	\$14.00 or \$55.50 depending on type of sensor
Theraband		\$6.50 per band
Laser		\$15.00 per 15 mins
Less than 24 hr cancel		\$42 per cancelled appointment
No Show		\$52 per cancelled appointment

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the item(s) or service(s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the item(s) or service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the item(s) or service(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the item(s) or service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



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
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"/>
Do you currently have an intrauterine device (IUD) implanted?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any history of or current sexually transmitted disease (ex. Herpes, HPV, chlamydia, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

Please check ✓ _____	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 past pregnancies and deliveries, 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.....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine compounds.....	<input type="checkbox"/>	<input type="checkbox"/>
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
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 ✓ _____	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.

NAME: (please print) _____

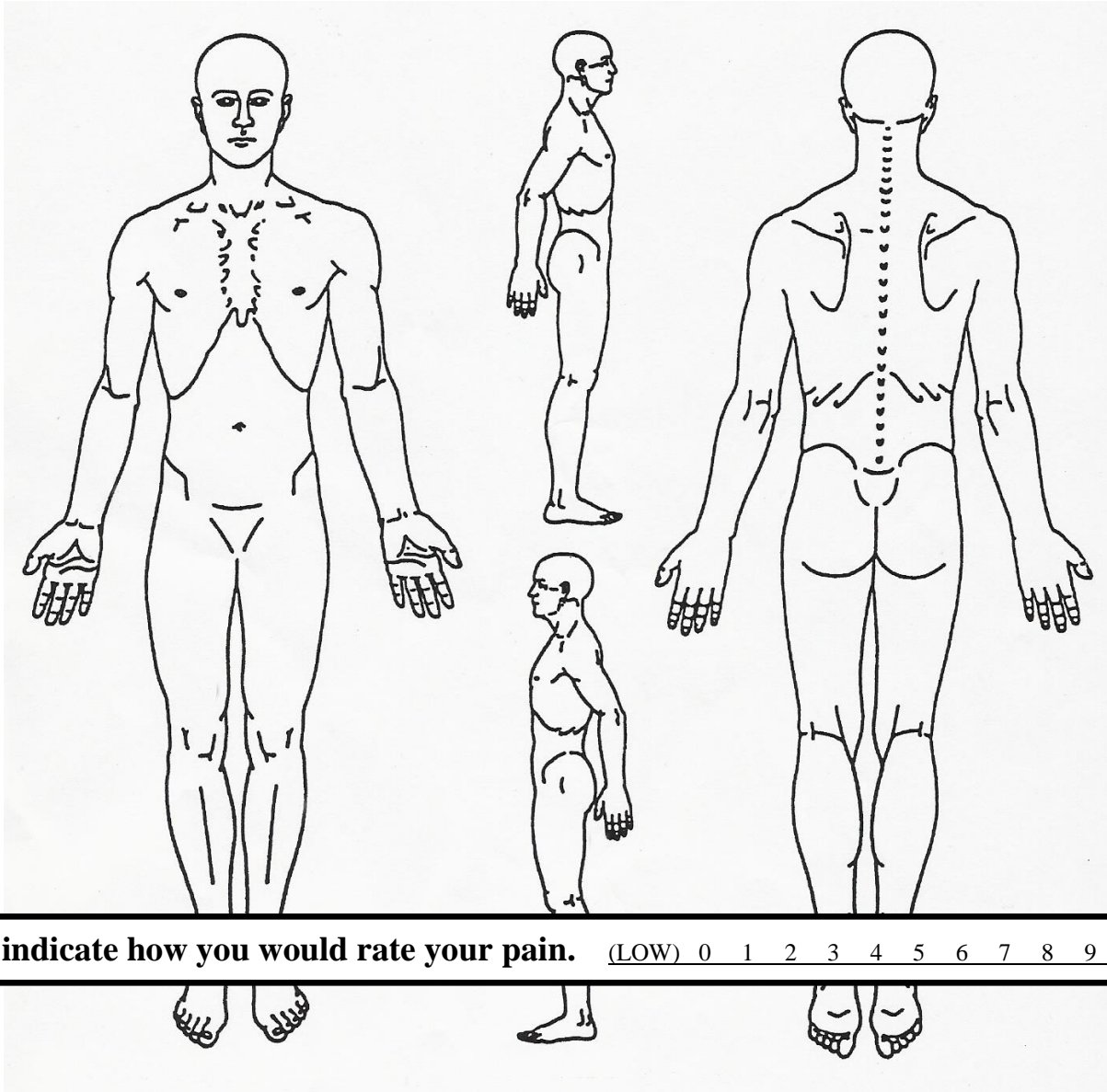
SIGNATURE: _____ DATE: _____



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: _____