

No Yes Condition

- History of recent infection
- Pain or discomfort in the chest of surrounding areas that occurs when you engage in physical activity
- Recent fever
- Difficulty breathing in an upright position
- HIV/AIDS
- Swelling of the ankles (recurrent and unrelated to injury)
- Diabetes
- Heart palpitations
- Pain in the legs that causes you to stop walking
- Corticosteroid use
- Birth Control pills
- Dizziness/Fainting
- High blood pressure
- Frequent urination
- Pregnancy, # of births _____
- Abnormal Weight
 gain loss
- Epilepsy/Seizures
- Visual Disturbances
- Do you have a **Pace Maker**?

No Yes Condition

- History of Low/Mid Back pain
- History of neck pain
- Arthritis
- Shortness of breath
- Allergies
- Asthma
- Urinary retention
- Aortic aneurysm
- Recent trauma
- Stroke (date) _____
- History of Tobacco use
- History of Alcohol use
- Sleep apnea
- Rheumatic Fever
- Hepatitis
- Osteoporosis
- Cancer/Tumor
- Prostate Problems
- High cholesterol
- Pulmonary Lung Disease
- Liver disease
- Kidney disease
- Thyroid disease
- Heart condition/surgery

Are you currently under the care of a M.D., Physical Therapist or a Chiropractor? Yes No
If yes, please describe condition. _____

Have you had surgery or been diagnosed with any disease in the past 12 months? Yes No
Date: _____ Surgery Type: _____

Have you had Spinal X-Rays, MRIs, CT Scans or any other imaging studies? Yes No
Date taken and area treated: _____

Are you taking any medications? If yes, please list the medications and indications:

What are your short term health goals (1-3mo)? :

What are your long term health goals (6mo-2yrs.)?

- Weight Loss
- Better nutritional habits
- Stress Reduction

- To get in better physical shape
- Other _____

Have you ever participated in an exercise or nutrition program before? If so, which one?

How many times a week do you perform weight bearing exercises (free weight, cables, bands)? _____

How many times a week do you perform cardiovascular activity (biking, running, walking more than 30 minutes)? _____

Do you have any problems with bones, joints, or muscles that may be aggravated with exercise?

On a scale of 1-10, please indicate your stress levels (1 being low, 10 being high)? _____

How many times a week do you work-out? _____

Insurance Information

Primary Insurance Carrier: _____

Insured's Name: _____ Date of Birth: _____

Insured's Mailing Address (if different than the patient) _____

Employer: _____

Insurance Phone#: _____

Member ID#: _____ Group #: _____

Secondary Insurance

Primary Insurance Carrier: _____

Insured's Name: _____ Date of Birth: _____

Insured's Mailing Address (if different than the patient) _____

Employer: _____

Insurance Phone #: _____

Member ID#: _____ Group #: _____

Attorney Information

**If you are being represented by an attorney, please include the following information:

Name of Firm: _____

Name of Representing Attorney: _____

Firm's Address: _____ City: _____ Zip: _____

Firm's Phone #: _____ Ext: _____

I have answered the Initial Health Status Questionnaire accurately and completely. I understand that my medical history is a very important factor in the development of my program at Omega. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my Clinician, may result in serious injury to me. If any of the above conditions change, I will immediately inform my Clinician of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire.

Patient Signature: _____

Date: _____

Parent or Guardian Signature: _____

Date: _____

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

As required by Health Information Portability and Accountability Act (HIPAA) OF 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This includes communicating with any Doctor's office and retrieving all records and reports related to your condition. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone

I want you to contact me by telephone at: _____

_____ **Do** _____ **Do not** leave messages on my answering machine

_____ **Do** _____ **Do not** leave messages with any other person

Please indicate name, if any, of individual(s) approved to take above messages:

Diagnosis & Treatment

I, _____ **Do** _____ **Do not** want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

Mail

I want you to contact me at the following address: _____

Signed: _____ Date: _____

Print name: _____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of patient: _____

OMEGA REHAB & SPORT

Welcome to OMEGA. We are pleased that you have chosen us for your health and wellness needs. This policy statement will acquaint you with our office policies as well as your financial responsibilities. Our staff is happy to assist you with any questions or concerns you may have.

Financial Responsibility

Rehabilitation (Physical Therapy/Chiropractic) Services

- Patients without insurance are asked to pay in full at the time of each appointment. For your convenience, we accept Visa and MasterCard.
- Patients with insurance are asked to pay their co-payments in advance for all appointments in that coinciding week. Please note that your insurance policy is a contract between you and your insurance carrier. Therefore, we expect you to know both the benefits and the limitations of your policy. We will not enter into disputes between you and your carrier. As a courtesy, we may obtain a quotation of benefits from your carrier, but this quotation is **NOT A GUARANTEE OF PAYMENT** since we are unable to verify the exact accuracy of the information. Please note, your treatment plan is based on medical necessity as determined by your referring physician and/or Dr. Khodabakhshian NOT the limitations imposed by your insurance carrier. You are responsible for knowing the limitations of your policy and for requesting alternative arrangements prior to exceeding benefit limits. We will handle your insurance billing needs for you and balance-bill you directly for any insurance portion, other than your co-pay, which is your financial responsibility.

Authorization and Assignment

I hereby authorize OMEGA Rehab & Sport to release any information deemed appropriate concerning my medical condition to my insurance company in order to process claims for charges incurred by me, and I release OMEGA Rehab & Sport of any consequence thereof.

In consideration of the services rendered to me by OMEGA Rehab & Sport, I authorize and direct payment to OMEGA Rehab & Sport for any sum owed on my account including any insurance company obligation and/or proceeds of any settlement in my name.

Signature: _____ Date: _____

Agreement to pay for services rendered

(Not applicable for authorized workers compensation patients)

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered to me by OMEGA Rehab & Sport (regardless of any insurance coverage). I also understand and agree that in the event my insurance company has not paid within 60 days, I am responsible for the balance. In the event that my insurance company forwards payment for services rendered by OMEGA Rehab & Sport to me, I will promptly deliver such payment to OMEGA Rehab & Sport. In addition, I understand and agree that if it becomes necessary for OMEGA Rehab & Sport to commence legal action for collection of any outstanding charges on my account and I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs and attorney fees.

Signature: _____ Date: _____

Past Due Policy

Please be advised that any amount owing on your account over 60 days is due and payable in full by the client. Accounts unpaid after 90 days will insure a 1.5% monthly charge (18% APR). Accounts which are over 120 days past due may be referred to our collection agency, unless specific arrangements have been made with our staff.

Returned Checks

There will be a \$40.00 fee imposed for all checks returned to this office.

Appointment Cancellation Policy

We require a minimum of 24-hour notice for any cancelled or re-scheduled appointment. Failure to give the required notification will result in a \$40.00 charge. If you fail to show for an appointment without any prior notification, you may be charged for the full time set aside for you. These charges will be billed directly to you as a missed appointment. Please note, missed appointments must be rescheduled, not skipped, as these sessions are in a series (as per your prescription) and the sequence must be adhered to.

Supplies

To aid in the success of your program, specific supplies may be suggested at the discretion of your Clinician. Some are available at Omega for purchase; otherwise your Clinician may recommend the specific place to acquire the item.

Authorization and Assignment

I hereby authorize OMEGA Rehab & Sport to release any information deemed appropriate concerning my physical status to my Primary Care Physician or referring Physician in order to facilitate the progression of my health.

In consideration of the services rendered to me by OMEGA Rehab & Sport, I authorize a direct payment to OMEGA Rehab & Sport for any sum owed on my account including any cancellation or late fees.

Signature: _____ Date: _____

