325 E. Rolling Oaks Dr., Suite 250
Thousand Oaks, CA 91361
805-230-1199

OMEGA REHAB & SPORT
ACTIVE CARE FOR EVERY BODY

Initial Health Status

Patient Name:_____ Date of Birth:_____ Sex M/F

Marital Status:_____ Email:_____

Address:_____City:_____ State:_____ Zip:_____

Mobile Phone:_____ Home Phone:_____ Other:_____

Social Security # :_____ Drivers License #:_____

Occupation:_____ Employer:_____ Phone:_____

Address:_____City:_____ State:_____ Zip:_____

Who may we thank for referring you here (Physician or other?)_____

Person to Contact in Case of Emergency

Name: _____ Relationship to Patient:_____

Mobile Phone:_____ Home Phone:_____ Other:_____

Address: Address:_____City:_____ State:_____ Zip:_____

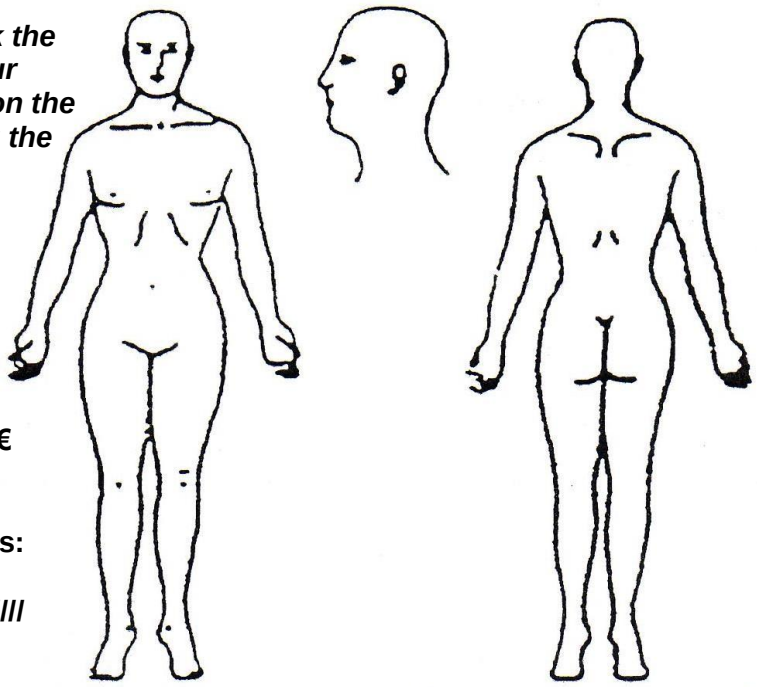
Primary Care Physician Name:_____ PCP/Phone:_____

If you are here for treatment of an injury, is the injury a result of: (please circle)

Work
Auto
Sports
Other

Date of injury/accident:
_____

Please mark the areas of your symptoms on the figure using the following symbols:



Aches: €€€€
Numbness: oooo
Pins/Needles: ….
Stabbing: /////

Circle the number that best represents your <u>current pain</u>.

No Pain **Most Severe**

0 1 2 3 4 5 6 7 8 9 10

No	Yes	Condition
___	___	History of recent infection
___	___	Pain or discomfort in the chest of surrounding areas that occurs areas 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

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
___	___	Do you have a **Pace Maker**?

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 (1-3months?):

_____

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

___ Weight Loss
___ Better nutritional habits
___ Stress Reduction
___ Strength Training
___ 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:_____ Phone#:_____

Member ID#:_____ Group #:_____

Insured's Name:_____ Date of Birth:_____

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

Address:_____City:_____ State:_____ Zip:_____

Employer:_____ Phone:_____

Secondary Insurance

Secondary Insurance Carrier:_____ Phone#:_____

Member ID#:_____ Group #:_____

Insured's Name:_____ Date of Birth:_____

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

Address:_____City:_____ State:_____ Zip:_____

Employer:_____ Phone:_____

Attorney Information

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

Name of Firm:_____

Representing Attorney:_____Phone:_____ Ext:_____

Address:_____City:_____ State:_____ Zip:_____

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:_____

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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:

Address:_____City:_____ State:_____ Zip:_____

Patient Signature:_____Date:_____

If not signed by the patient, please indicate relationship:

Name of Patient:_____

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

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:_____

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.

Patient Initials:___

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.

Patient Initials:___

Returned Checks

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

Patient Initials:___

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.

Patient Initials:___

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:_____

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PATIENT ACKNOWLEDGEMENT OF OMEGA REHAB & SPORT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read, understand, and have been given a copy of OMEGA REHAB & SPORT "Notice of Privacy Practices".

I, _____, understand that OMEGA REHAB & SPORT may use and disclose my health medical information for the purposes of wellness services, treatment, payment, and health care operations.

- ***Wellness Services and Treatment*** include activities performed by all OMEGA REHAB & SPORT staff and other types of health Care and administrative professionals involved in providing care to the above-mentioned patient, including those coordinating or managing care with third parties, and consultations with and between other health care providers and administrative professionals.

- ***Payment*** includes activities involved in collecting for our services which may include the use of a collection agency.

- ***Health Care Operation*** includes the necessary administrative and business functions of our office

Because OMEGA REHAB & SPORT has reserved the right to change our privacy practices in accordance with the law, the terms on contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will give you a copy of the Notice on your first visit to us after the effective date of the then current Notice.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. WE are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency medical treatment.

I understand that I have the right to revoke this signed acknowledgement, provided that I do so in writing, except to the extent that OMEGA Rehab & Sport has already used or disclosed the information in reliance on this acknowledgement.

_____ _____

Signature of patient Date

_____ _____

Signature of parent or guardian Date

Or

_____ _____

Signature of person authorized by law Date