Wellworks
Physical Therapy and Rehabilitation Inc.
500 W. Glenoaks Blvd. · Glendale, CA 91202-2813 · Tel: 747-272-0027 · Fax: 747-272-0041

Date _____
Fecha

Social Security Number _____ - _____ - _____
Seguro Social

History **Have you ever been a patient at Wellworks Physical Therapy and Rehabilitation Inc.?** ☐ **Y** *S* ☐ **N** *N*
Historia *Ha sido alguna vez paciente de Wellworks Physical Therapy and Rehabilitation, Inc.?*

Date of Injury or Onset of Illness _____
Fecha del dano

Referring Physician _____
Médico

IS THIS INJURY WORK RELATED ? _____ ***AUTO ACCIDENT?*** _____

Phone Number (____) _____- _____
Teléfono

Patient Information/Informacion Del Paciente

Legal Name (Last, First, Middle)_____
Nombre Legal (Apellido, Primer Nombre)

Street Address _____ **City** _____ **State** _____ Zip _____
Dirección (No P.O. Box) *Ciudad* *Estado* *Zip*

Home Phone (____) _____**Cell Phone** (____) _____ **Date of Birth** _____ **Sex** ☐ M ☐ F
Teléfono *Teléfono celular* *Fecha de Nacimiento* *Sexo* *M* *F*

E-mail Address: _____

California Driver's License # _____ **Patient Status** ☐ Single ☐ Married ☐ Other
Numbero de Licencia de California *Circle all that apply* ☐ Employed ☐ Full-time student ☐ Part-time Student

Employer _____
Empleo

Employer Address _____
Dirección De Empleo

Employer Phone (_____)_____ **Your Occupation** _____
Teléfono de Empleo *Ocupación*

In case of emergency who should be notified? _____ **Phone Number** (_____) _____
En caso de emergencia a quién notificamos *Teléfono*

*****Primary Physician** _____
Familia Médico

PRIMARY INSURANCE INFORMATION/ INFORMACION DE SEGURO PRINCIPAL

Insurance Company Name _____
Comapñia de seguro

Insurance Address (To Mail Claims) _____
Dirección (Para Rediamos)

Phone Number to Verify Benefits (____)_____
Teléfono para Verificar Beneficios

Insured or Guarantor Name _____ **Relation to Patient** _____ **Sex:** ☐ M ☐ F
Nomber del Asegurado *Parentesco con el Paciente*

Street Address _____**City** _____ **State** _____ **Zip** _____
Dirección *Ciudad* *Estado* *Zip*

Subscriber name: _____ **Date of Birth** ____/____/____ **Employer Name** _____
Fecha de Nacimiento *Nombre de Empleado*

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Health History Questionnaire

Name: _____ Date: _____

To help us with your therapy, please indicate if any of these conditions apply to you:

	Yes	No		Yes	No
• High Blood Pressure	☐	☐	• Pacemaker	☐	☐
• Diabetes	☐	☐	• Chest Pain	☐	☐
• Arthritis	☐	☐	• Smoking	☐	☐
• Osteoporosis	☐	☐	• Shortness of Breath	☐	☐
• Headaches	☐	☐	• Respiratory Disease	☐	☐
• Dizziness	☐	☐	• Hearing Loss	☐	☐
• Stroke	☐	☐	• Impaired Vision	☐	☐
• Seizures	☐	☐	• Anxiety Disorder	☐	☐
• Cancer	☐	☐	• Depression	☐	☐
• Hepatitis/HIV Positive/TB	☐	☐	• Height	_____	
• Pregnant	☐	☐	• Weight	_____	

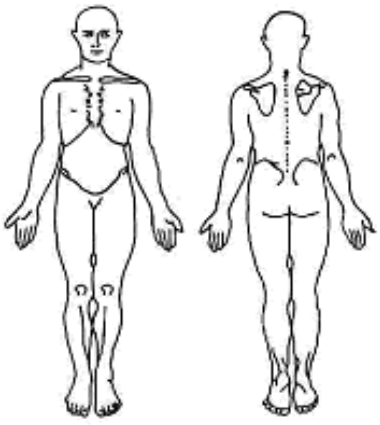
Other Conditions (include allergies): _____

Past Medical History (include dates of surgeries, significant injuries, and any metal implants):

_____

_____

Medications: _____



Your pain is: ☐ Constant ☐ Intermittent

On a scale of 0-10 (0 = no pain, 10 = worst imaginable pain),

your pain is currently a ____ and ranges from ____ to ____.

Please indicate the location of your symptoms on the left:
O = circle areas with pain
X = mark an X where there is most pain
/// = shade areas with numbness, tingling, or burning

Sports & Activities (bowling, golf, jogging, etc): _____

Goals: _____

Primary Physician: _____ Phone Number: _____

Wellworks
Physical Therapy and Rehabilitation Inc.

Cancellation and No-Show Policy

We strive to provide our patients with the highest quality of care and service. We are committed to your wellbeing—and the restoration of your physical abilities is something that everyone in our clinic takes seriously.

Because we care very much about you, we emphasize the importance of your own commitment to therapy. We know from experience that this is essential for your recovery.

Your adherence to the recommended number of treatments is a vital component of your progress. Thus we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep **all** your appointments and suggest that you write down the time of your visits so that you do not forget.

With the exception of serious emergencies, it is expected that you will keep all your appointments. If you need to re-schedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day. You must leave a voicemail if you are unable to call during business hours.

There is a $35 charge for a no-show or cancellation without 24-hour notice. The charge will not be covered by your insurance, but will have to be paid by you personally. We require a credit card number on file to reserve your next appointment, and we will charge your credit card for any future cancellations without proper notice.

If you are late for your appointment, we will try to accommodate you. However, you may not receive full treatment as scheduled.

For Worker's Compensation and Personal Injury patients, we are required to forward documentation of any missed appointments to your case manager and primary physician. This could jeopardize your claim.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and to inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: _____
Patient Signature

Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

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.

This notice takes effect on September 14, 2018 and remains in effect until it is replaced.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality of care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share the medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share you medical information if it is necessary to prevent a serious threat to your health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcements officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purpose of sending you appointment postcards or other wise reminding you or your appointment.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, the charge is $35.00. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, or health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you y different means of at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Wellworks Physical Therapy and Rehabilitation, Inc.
500 W. Glenoaks Blvd.
Glendale, CA 91202

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.