

**COURY AND BUEHLER PHYSICAL THERAPY
MEDICAL HISTORY QUESTIONNAIRE**

CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Age: _____

Cell Ph: _____ Home Ph: _____ Work Ph: _____

Email: _____ Date of Birth _____ SSN _____ Gender _____ Marital Status _____

Address: _____ City _____ State _____ Zip _____

Have you been a patient here before? Yes or No (circle one) If yes, when? Month/Year: _____

EMERGENCY CONTACT SECTION

Last Name: _____ First Name: _____

Relationship: _____ Phone: _____

EMPLOYER SECTION

Occupation: _____

Name: _____ Phone: _____

Address _____ City _____ State _____ Zip _____

Please take a moment to tell us exactly how you found out about our facility.

1. Doctor? Name: _____
2. Family Member/Friend? Name: _____
3. Mailer? (Please indicate what you received in the mail) _____
4. Worker's Comp Adjuster Referral? _____
5. Yellow Pages? _____
6. Website? _____
7. Insurance Company/Website Listing? _____
8. Advertisement: which one? _____
9. Other: _____

CURRENT MEDICAL PROVIDERS

Please list all physicians whose care you are under. Please include their information as follows:

Doctor's Name (First, Last): _____ Phone # _____

Address: _____ City/State/Zip: _____

Doctor's Name (First, Last): _____ Phone # _____

Address: _____ City/State/Zip: _____

Doctor's Name (First, Last): _____ Phone # _____

Address: _____ City/State/Zip: _____

MEDICAL HEALTH HISTORY

1. Have you had treatment for this/these problems before? Yes No
If yes, where and when were you treated? _____

2. Have you had surgery related to this/these problems? Yes No
If yes, what type of surgery did you have and when was the surgery? _____

3. Have you had any injections for your current problem? Yes/No If yes, Location: _____

4. Do you currently have any metal implants? Yes No

5. Do you currently have a pacemaker? Yes No

6. Do you have any communicable diseases? Yes No

7. Do you smoke? Yes No

8. List any medications you are currently taking: _____

9. In general, would you say your overall health right now is: (circle one) Excellent Very Good Good Fair Poor

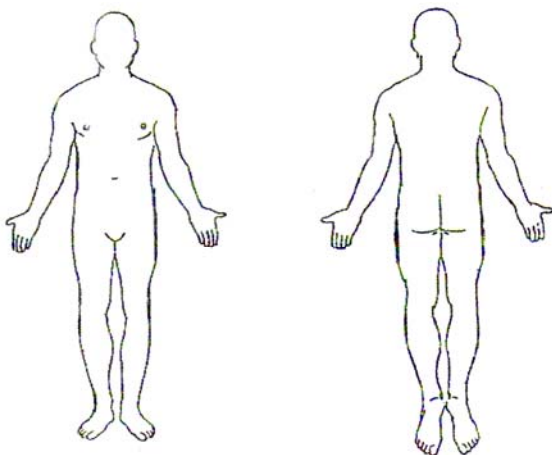
DESCRIPTION OF SYMPTOMS

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

DESCRIBE HOW YOUR INJURY OCCURRED OR WHEN/HOW YOUR SYMPTOMS BEGAN:

CURRENT COMPLAINT: _____

PLEASE INDICATE ON THE DIAGRAM WHERE YOU EXPERIENCE YOUR PAIN/SYMPTOMS.



MY PAIN IS INCREASED BY:

MY PAIN IS DECREASED BY:

TYPE OF PAIN: shooting burning aching sharp dull tingling other: _____

WHEN DO YOU EXPERIENCE YOUR PAIN/ SYMPTOMS:

___X/Week AM/PM With Activity:_____

THE FREQUENCY OF YOUR SYMPTOMS ARE:

Constantly (76-100% of day); Frequently (51-75% of day); Occasionally (26-50% of day); Intermittently (0-25% of day)

HOW ARE YOUR SYMPTOMS CHANGING?

Getting Better Not Changing Getting Worse

DURING THE PAST 4 WEEKS, THE MOST SEVERE INTENSITY OF YOUR SYMPTOMS WERE:

1 2 3 4 5 6 7 8 9 10

DESCRIPTIONS OF FUNCTIONAL LIMITATIONS AND GOALS:

WHAT ACTIVITIES IN YOUR DAILY LIFE ARE AFFECTED THE MOST BY YOUR CURRENT COMPLAINT, INCLUDING RECREATIONAL/ SOCIAL ACTIVITIES, FUNCTIONAL ACTIVITIES, AND WORK AROUND THE HOUSE?

IF YOU HAVE LIMITATIONS/RESTRICTIONS AT YOUR JOB, WHAT ARE THEY?

HOW MUCH HAS THE PAIN INTERFERRED WITH YOUR WORK?

Not at all A little bit Some of the time A little of the time None of the time

WHAT ARE YOUR GOALS FOR THE FIRST 2 WEEKS? _____

WHAT ARE YOUR GOALS AT 6-8 WEEKS? _____

Coury & Buehler Physical Therapy

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____ hereby consent to the therapeutic procedures outlined below, to be performed by Coury and Buehler Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions &/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, E-stim and ultrasound; and special procedures such as taping, neuromuscular E-stim and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Coury and Buehler Physical Therapy, Inc. or from any other source.

I certify that I have read and understand the above consent statements:

Patient's Signature: _____

Date: _____

Physical Therapist's Signature: _____

Date: _____

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Coury and Buehler Physical Therapy, Inc. I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, Auto), then I am financially responsible and agree to pay for all charges related to services provided to the patient at the medical group.

Although I have requested Coury and Buehler Physical Therapy to bill my insurance company on my behalf, I clearly understand that I am responsible directly to Coury & Buehler Physical Therapy, Inc. for payment on my account regardless of the status of my insurance claim.

Patient's Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name: _____

Date: _____

Patient's Signature: _____

Parent or Authorized Representative (if applicable)

Revised: 03/07/05

COURY & BUEHLER PHYSICAL THERAPY – PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of an person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physical Therapist or Authorized Representative's Signature (Date)

By: _____
Patient's or Patient Representative's Signature (Date)

By: _____

Print or Stamp Name of Physical Therapist, Medical Group or Association

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

COURY & BUEHLER PHYSICAL THERAPY

PATIENT COMMITMENT & MISSED APPOINTMENT POLICY

Dear Patient:

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

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

It is expected that you keep all your scheduled appointments.

A 24 hours notice is required for an appointment to be rescheduled. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. This appointment needs to be in the same week of the original appointment, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge a \$ 50 fee.

The only exception to the cancellation fee is in the case of an emergency. If repeated cancellations, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

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

Sincerely,



Brandon J. Buehler, DPT, MPT



Richard Coury, MPT, OCS, ATC

I certify that I have read and understood the above policy:

Print Name: _____

Date: _____

Signature: _____

Date: _____

COURY & BUEHLER PHYSICAL THERAPY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

SUMMARY OF NOTICE OF PRIVATE PRACTICES

*This summary is provided to assist you in understanding
the Notice of Privacy Practices*

The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information. We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members to close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product deficits or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.