6221 Wilshire Blvd., #616 Los Angeles CA 90048
Phone: 323 939-7050 Fax: 323 939-7056

PATIENT REGISTRATION FORM

Name: _____ Sex: M/F D.O.B.: _____

Address: _____ City/State _____ Zip: _____

Home #: _____ Cellular #: _____ Work #: _____

Referred By: _____ Telephone #: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Occupation: _____ Date of Injury/Onset: _____

Area(s) of Complaint: _____

Injury Caused By: Vehicle: ☐ Slip/Fall: ☐ Sports: ☐ Illness: ☐ Work Related: ☐ Other: ☐ _____

Drivers License #: _____ State: _____ SS#: _____-_____-_____

Employer: _____ Telephone #: _____

Address: _____ City/State: _____ Zip: _____

Responsible Person: (check one) Self: ☐ Spouse: ☐ Parent: ☐ Other: ☐ _____

Family Physician: _____ Telephone #: _____

In Case of Emergency: _____ Telephone #: _____

INSURANCE INFORMATION

Name of Insured: _____ Insured SS#: _____-_____-_____

Policy/Group #: _____ Primary/Secondary (circle one)

Ins. Co. Name: _____ Telephone #: _____

Address: _____ City/State: _____ Zip: _____

AUTO MEDICAL PAY INSURANCE COMPANY:

Name of Insured: _____ SS #: _____-_____-_____

Ins. Co. Name: _____ Telephone #: _____

Address: _____ City/State: _____ Zip: _____

Policy #: _____ Claim #: _____

Attorney: _____ Telephone #: _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION & FINANCIAL AGREEMENT

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my care, regardless any third party responsibility.

Signature: _____ **Date:** _____

GOLD WELLNESS
Physical Therapy Sports Medicine
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Phone: 323 939-7050 Fax: 323 939-7056

CANCELLATION / NO SHOW POLICY

As a patient in our clinic, it will be your responsibility to keep scheduled appointments. The clinic will require notification of cancellation at least 24 hours prior to the appointment or earlier if possible. You can do this by calling our clinic at (323) 939-7050.

There is a charge of $50.00 for **NO-SHOW** appointment. Payment of the **NO-SHOW** fee must be made in cash or valid credit card before further appointments are allowed.

I have read and understand the above policy.

Patient Name (please print):_____ Date: _____

Patient Signature: _____

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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.

Gold Wellness, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"On occasion it may be necessary to seek consultation regarding your condition from other health care providers associated with Gold Wellness, Inc."

"It is our policy to provide a substitute health care provider, authorized by Gold Wellness, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Gold Wellness, Inc. for health care services rendered. If you pay for your health care services personally we will, for a fee of $5.00/claim, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Law.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect fugitive, material witness or missing person, complying with a court order or subpoena, and other low enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefit purposes.

Contacting You
We *may* contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Gold Wellness, Inc. sponsored fund-raising events."

Change of Ownership
In the event that *Gold Wellness, Inc.* is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *Gold Wellness, Inc.* is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right Io inspect and copy your health information.

You have a right to request that *Gold Wellness, Inc.* amend your protected health information. Please be advised, however, that *Gold Wellness, Inc.* is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by *Gold Wellness, Inc.*

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Gold Wellness, Inc. reserves the right to amend this Notice of Privacy Practices at any time in to future and will make the new provisions effective for all information that it maintains. Until such amendment is made, *Gold Wellness, Inc.* is required by law to comply with this Notice.

Gold Wellness, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Vadim Gold, PT by calling this office at 323-939-7050. If Vadim is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how *Gold Wellness, Inc.* has handled your health information should be directed to Vadim by calling this office at 323-939-7050. If Vadim is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights
200 Independence Avenue, S.W. Room 509F HHH Building Washington DC 20201
This notice is effective as of 05.01.2003

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NOTICE OF PRIVACY PRACTICES

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide *Gold Wellness, Inc.* with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Patient's Signature _____ Date _____

Authorized Facility Signature _____ Date _____

Gold Wellness Inc.

Medical History Questionnaire / Intake Form

Date:___-___-___ **Name:**_____

Please specify the body part you have injured. _____ **Has this been treated before Y / N**
if yes please state treatment type and dates_____

_____

Have you had Surgery for this injury? YES NO **Number of Surgeries: 1 2 3 4** ____
Type of Surgery:_____ **Took Place in: Hospital Surgery Center**

Previous Surgeries Y /N : List Surgeries 1. _____ **2.** _____ **3.** _____

Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO
Anti-inflammatories ____ Muscle Relaxers ____ Pain Medication _____
Are You Allergic to any Medications? YES NO

List Your Medications:	**4.**
1.	**5.**
2.	**6.**
3.	**7.**

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other:_____

Do you now have or Have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are You Pregnant?	___	___
Emotional/Psychological Problems	___	___	Do You use Tobacco?	___	___

List any other information that would assist us: _____

Are you aware of your diagnosis? YES NO Based on your awareness, What are your rehabilitation expectations/goals while in this program?

_____

Patient/Guardian Signature: _____ **Date:** _____