Ultrahealth
Physical Therapy and Training

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Home Address _____ Soc. Sec. No. _____

_____ Home Phone _____

_____ Work Phone _____

Email _____ Cell Phone _____

Physician _____ Date of Surgery _____

Date of injury/flare up _____ Cause _____

Date of next Dr. appt. _____

Referred to Ultrahealth by _____

Is a 3rd party settlement anticipated (lawsuit, auto accident, etc)?

Yes ◯ No ◯

EMPLOYER INFORMATION

Name _____

Address _____

_____

_____

Phone _____

LEGAL INFORMATION (if lawsuit)

Attorney _____

Address _____

_____

_____

Phone _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Home Phone _____

Work Phone _____

TODAY'S DATE _____

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PATIENT HISTORY

Name: _____ Sex: _____ Date of Birth: _____

Please complete all requested information.

1. Have you ever had? (If yes, please explain)

High blood pressure	○ No	○ Yes	_____
Heart or Circulation Disorders	○ No	○ Yes	_____
Seizures	○ No	○ Yes	_____
Dizzy Spells	○ No	○ Yes	_____
Diabetes	○ No	○ Yes	_____
History of Smoking	○ No	○ Yes	_____
Cancer	○ No	○ Yes	_____
Arthritis/Osteoarthritis	○ No	○ Yes	_____
Osteoporosis	○ No	○ Yes	_____
Immune Deficiency Disease	○ No	○ Yes	_____
Other	○ No	○ Yes	_____

2. Please list surgeries you have had; please give procedures and dates if possible:

_____

3. Please list recent diagnostic studies (Cat-scan, MRI, X-rays):

_____

4. Do you have any METAL anywhere in your body; pins/plates post-fracture, or pacemaker (other than teeth)? ☐ N ☐ Y Describe: _____

5. (For women only) Are you currently pregnant? ☐ N ☐ Y Date of last menstrual cycle: _____

6. Do you have any abnormal trouble with vision? ☐ N ☐ Y /Hearing? ☐ N ☐ Y

7. List any allergies you have: _____

8. Have you ever taken steroids/anti-coagulants for an extended period of time? ☐ N ☐ Y

9. Have you had any unusual weight gain or loss lately? ☐ N ☐ Y

10. List medications you are now taking: _____

_____

11. Have you ever had physical therapy treatments before? ☐ N ☐ Y If yes, please indicate where, when, and for what problem: _____

_____

12. Describe briefly the history of your present <u>ACCIDENT, INJURY, OR ILLNESS:</u>

Onset date: _____ description: _____

_____

_____

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LATE CANCELLATION POLICY

Please understand that missed appointments are an impact to the clinic and to the availability of the therapist's time for other patients. Also it is very important to show up to your appointment on time.

You will be charged $60 for a missed or too late to be seen appointment as well as a cancellation without 24 hours notification.

This charge must be paid by you.-

– Your insurance will not cover charges for missed appointments.

Patients Signature:_____

Date:_____

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PATIENT POLICY SHEET

Welcome to ULTRAHEALTH Physical Therapy. Our goal is to provide quality patient care as efficiently as possible. To this end, we have established the following policies and billing plans. Therapy is provided on an appointment basis only. We ask that you contact us if you will be late and we require 24 hour notice if you must cancel an appointment.

We ask that you always inform your therapist of any upcoming doctor's appointments (if you have an attending physician).

Please read the following billing options carefully and select one:

PLAN A
You will be billed directly for all charges. $150 is due today, and thereafter you will be billed monthly. You will be responsible for filing claims with your insurance company although we will be happy to assist you in any way we can.

PLAN B
As a convenience to you, ULTRAHEALTH will bill your insurance company directly. You will be required to provide insurance information at the front desk and pay a $80 deposit before leaving the office today. The deposit will be applied to charges not paid in full by your insurance carrier. Any remaining balance will be refunded to you.

Please note that you are still responsible for payment of all charges incurred at ULTRAHEALTH. If your insurance company makes only a partial payment for charges incurred, you will be billed for the remaining balance after deducting your deposit. If your insurance company fails to make any payment within 90 days, all charges will become due and payable by you.

PLAN C
If this is a work related injury and you are covered by workman's compensation insurance, we will file all claims and accept assignment for payment. You must provide us with complete billing information.

PLAN D
If you belong to a health plan contracted with ULTRAHEALTH, we will file all forms and accept assignment for payment. You are responsible for any co-payment at the time of service. You are also responsible for verifying your own eligibility and coverage at ULTRAHEALTH.

Please note: Any charges not specifically covered by your health plan (for any reason), are your responsibility. You will be billed accordingly.

Check one: PLAN A ☐ PLAN B ☐ PLAN C ☐ PLAN D ☐

Signature_____ Date_____

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OTHER PHYSICAL THERAPY SERVICES

Have you received physical therapy or rehabilitation for this or a similar injury/condition at any other time:

○ No

○ Yes Please list below approximate dates and name of clinic.

DATE	CLINIC	INJURY

Signature _____ Date _____

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ULTRAHEALTH, INC.'s LEGAL DUTY

ULTRAHEALTH, INC., is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

ULTRAHEALTH, INC., uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ULTRAHEALTH, INC., may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

ULTRAHEALTH, INC., may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ULTRAHEALTH, INC. 's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

ULTRAHEALTH, INC., may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ULTRAHEALTH, INC., will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ULTRAHEALTH, INC., may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ULTRAHEALTH, INC.'s health information practices or if you have a complaint, please contact the following person:

ULTRAHEALTH, INC.
Office Administrator
220 Bush St., Suite 110, San Francisco, CA 94104
Telephone: 415 986-4979 Fax: 415 986-6951

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ULTRAHEALTH, INC.
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand ULTRAHEALTH, INC. 's Notice of Information Practices. I understand that ULTRAHEALTH, INC., may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ULTRAHEALTH, INC., will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in ULTRAHEALTH, INC.'s Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date