

**Balance Rehabilitation, Inc.**  
**Physical Therapy – Occupational Therapy – Mental Health and Social Services**

Date \_\_\_\_\_

**Patient Information**

Patient Name \_\_\_\_\_  
Last First Middle Initial

Home Phone Number \_\_\_\_\_ Mobile Phone Number \_\_\_\_\_  
(Area Code) Number (Area Code) Number

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sex: M F Marital Status: S M D W Drivers License Number \_\_\_\_\_ State \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone Number \_\_\_\_\_ E-mail \_\_\_\_\_  
(Area Code) Number

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_  
Name Relationship (Area Number) Number

Is this injury the result of a:

Motor Vehicle Accident? Y N If yes, State of Accident \_\_\_\_\_ Date of Accident \_\_\_\_\_

Work Related Injury? Y N

Is an attorney Involved? Y N

**Assignment of Benefits / Release of Information:** I hereby authorize payment directly to Balance Rehabilitation, Inc. for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due. I authorize the release of any medical information necessary to process claims.

\_\_\_\_\_  
Patient Signature (Parent or Guardian if patient is a minor) Relationship Date

Balance Rehabilitation, Inc.  
Physical Therapy – Occupational Therapy  
Medical Screening

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: M F

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

Hand preference:    Right   Left

Have you been a patient here before?    Yes   No

Have you ever had or do you currently have any of the following:

Cancer	yes	no	Allergies/Asthma	yes	no
Diabetes	yes	no	Fractures	yes	no
High blood pressure	yes	no	Headaches	yes	no
Heart disease	yes	no	Hernia	yes	no
Angina/chest pain	yes	no	Incontinence	yes	no
Stroke/Parkinson's	yes	no	HIV/AIDS	yes	no
Osteoporosis	yes	no	Kidney problems	yes	no
Osteoarthritis	yes	no	Shortness of breath	yes	no
Rheumatoid arthritis	yes	no	Pregnant (currently)	yes	no
Diet/nutritional concerns	yes	no	Depression	yes	no
Nausea/vomiting	yes	no	Anxiety	yes	no
Changes in appetite	yes	no	Under stress	yes	no
Diarrhea/constipation	yes	no	Difficulty Sleeping	yes	no
Difficulty swallowing	yes	no			

Please list any other medical conditions not listed above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications/supplements/vitamins/herbs you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Physical Activities in Occupation(e.g. sitting, bending, heavy lifting, computer, etc.): \_\_\_\_\_  
\_\_\_\_\_

Sports, hobbies, other activities, and frequency/hours involved: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke tobacco:    yes    no  
If yes \_\_\_\_packs per day for \_\_\_\_years  
Date of last tobacco use \_\_\_\_\_

Do you drink alcoholic beverages?    yes    no  
If yes, drinks \_\_\_\_\_ per week

Describe your current symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

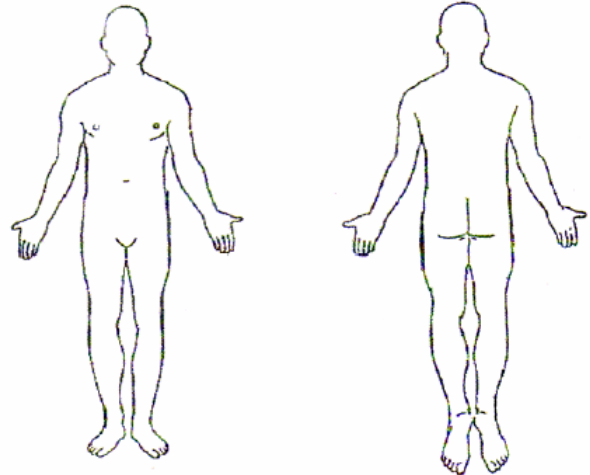
When did your symptoms start? \_\_\_\_\_

How did your symptoms start? \_\_\_\_\_

\_\_\_\_\_

How often do you experience your symptoms?

- 1. constantly (76-100% of the day)
- 2. frequently (51-75% of the day)
- 3. Occasionally (26-50% of the day)
- 4. Intermittently (0-25% of the day)



What is the nature of your symptoms?

- 1. sharp
- 2. dull ache
- 3. numb
- 4. shooting
- 5. burning
- 6. tingling

How are your symptoms changing?

- 1. Getting better
- 2. Not changing
- 3. Getting worse

Please indicate on the diagram where you experience your pain/symptoms

Pain increases during following activities: \_\_\_\_\_

Pain decreases during following activities: \_\_\_\_\_

During the past 4 weeks:

a. indicate the average intensity of your symptoms

None Unbearable

0    1    2    3    4    5    6    7    8    9    10

b. How much has pain interfered with your normal work (including work and housework)?

- 1. Not at all
- 2. A little bit
- 3. Moderately
- 4. Quite a bit
- 5. Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities?

- 1. Not at all
- 2. A little bit
- 3. Moderately
- 4. Quite a bit
- 5. Extremely

In general would you say your overall health right now is...

- 1. Excellent
- 2. Very good
- 3. Good
- 4. Fair
- 5. Poor

Who have you seen for your symptoms? 1. no one    3. medical doctor    5. other

2. chiropractor    4. physical therapist

a. What treatment did you receive and when? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed:

1. x-rays *date*: \_\_\_\_\_    3. CT scan *date*: \_\_\_\_\_

2. MRI *date*: \_\_\_\_\_    4. Labs *date*: \_\_\_\_\_

Have you had similar symptoms in the past: yes    no

a. if you have received treatment in the past for the same or similar symptoms, who did you see?

- 1. no one
- 2. chiropractor
- 3. medical doctor
- 4. physical therapist
- 5. other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# BALANCE REHABILITATION, INC.

## Financial and Practice Policies

### PLEASE INITIAL EACH PARAGRAPH

1. I, \_\_\_\_\_, understand **I am ultimately financially responsible** for the professional services that I am about to receive. I promise to pay for these charges in a timely manner. I realize that as a service to their patients, Balance Rehabilitation, Inc. (Balance) will bill my insurance company for services rendered. I understand that it is the policy of Balance to try every possible means to receive payment from my insurance company, but **if** in fact, they are unable, that I will be personally responsible for any usual, customary, or reasonable balance that may exist.

2. I, \_\_\_\_\_, understand that it is **my own responsibility to understand my insurance coverage** as it relates to the services I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card that I can call at any time to ask any questions regarding coverage, eligibility, exclusions, deductibles, co-pays, or any other inquiry I may have. I understand that Balance in no way has any power to dictate policy or procedure of my own insurance company.

3. I, \_\_\_\_\_, understand that **my own insurance company** decides what to reimburse Balance only after bills are submitted and reviewed. Balance has no authority or ability to decide what treatments will/will not be paid nor at what price. Only my insurance company knows this information once bills are submitted.

4. I, \_\_\_\_\_, understand that if **I have chosen to purchase an insurance policy with a large deductible**, Balance was in no way a part of that decision and cannot be expected to offer discounts because of this predictable and personal financial decision.

5. I, \_\_\_\_\_, understand that **late cancellations (less than 24 hours notice) and no-show appointments** will be subject to a \$25.00 charge. I also realize that any future appointments scheduled will need to be rescheduled as to allow choice of timeslots for more consistent patients.

6. I, \_\_\_\_\_, understand that for **privacy and safety** concerns, Balance cannot allow anyone other than the patient to be in the treatment area. A family member is welcome to observe during the initial evaluation.

***Anyone accompanying the patient after the initial evaluation must wait in the waiting room.***

7. I, \_\_\_\_\_, understand that if my insurance policy has a **deductible larger than \$400**, and **my own** insurance company says that it has not been met, that I will need to pay \$150 for the first visit, and \$100 thereafter until my deductible has been met, before services are rendered.

8. I, \_\_\_\_\_, understand that being on time, dressed for therapy with comfortable attire, and mobile phones quiet, will help all of us provide and receive the best therapy possible.

### **Assignment of Benefits**

I have read and I agree with the above policies. I hereby authorize my insurance benefits to be paid directly to BALANCE REHABILITATION, Inc. I also authorize BALANCE REHABILITATION, Inc. to release any necessary information to process this claim.

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Signature

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Date

# BALANCE REHABILITATION, INC.

## NOTICE OF PRIVACY PRACTICES

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

### **SUMMARY:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights.

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. A complete copy of our privacy practices is available at any time in our waiting room or upon request. If you have any questions about this notice please contact the following Privacy Officer.

Effective Date of this Notice: 09/16/08  
Contact Person: Mark Wegener – Privacy Officer  
25971 Pala #110 Mission Viejo, California 92691  
(949) 465-9500 E-mail mark@balancerehab.net

### **PLEASE INITIAL:**

\_\_\_\_\_ I hereby acknowledge that I have had the opportunity to review a copy of this practice's *NOTICE OF PRIVACY PRACTICES*. I understand that if I have questions or complaints regarding my privacy rights that I may contact the privacy officer. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way during my course of treatment.

## **DRIVING DIRECTIONS – BALANCE REHABILITATION**

### **From the FIVE Freeway:**

Take the ALICIA PARKWAY exit EAST into Mission Viejo.

-from Irvine (heading South) turn left off of the freeway

-from San Clemente (heading North) turn right off of the freeway

Proceed on Alicia Parkway approximately 1.5 miles.

Turn LEFT onto Jeronimo.

Make your first available RIGHT onto ACERO.

Make your first available LEFT onto MAQUINA.

MAQUINA will veer to the RIGHT and become PALA.

We are the SECOND driveway on your LEFT.

### **From Rancho Santa Margarita:**

Take Alicia Parkway west towards the FIVE Freeway.

Turn RIGHT onto VIA LINDA.

Make your first LEFT onto MADERO.

Make your first LEFT onto PALA.

We are the Fifth Driveway on your RIGHT.

**25971 PALA #110**

**MISSION VIEJO, CA 92691**

**(949) 465 – 9500**

**ADLIN CONSTRUCTION COPANY'S OFFICE BUILDING IS IN THE FRONT.  
WE ARE LOCATED IN THE REAR OF THE BUILDING. PLEASE PULL TO  
THE BACK OF THE PARKING LOT. PARKING IS AVAILABLE IN THE  
REAR.**