



Physical Therapy
Pilates
Gyrotonic®

12930 Ventura Blvd.
Suite 226A
Studio City, CA 91604
818-907-0008 phone
818-907-0088 fax
www.coreconditioningpt.com

2520 West Olive Ave
Suite 300
Burbank, CA 91505
818-729-9419 phone
818-729-9559 fax
www.coreconditioningpt.com

Our Mission

At Core Conditioning we strive to enhance the overall health and quality of life for our clients. We want to help create a balanced lifestyle that will contribute to the individual's long-term physical, emotional, and social growth. We aim to provide high quality rehabilitation in a safe, serene and nurturing environment. Our goal is to create the best combination of physical therapy and state of the art integrated fitness to improve overall well-being and awaken the spirit by offering a variety of healing modalities.

Cancellation/Change Policies

Cancelling a Physical Therapy Appointment

If you cancel a PT appointment less than 24 hours prior to your scheduled time, you are subject to a \$75 late cancellation fee. Cancellation fees may not be applied towards your deductible, or billed to your insurance company.

Rescheduling Physical Therapy Appointments

In the event that you must re-schedule a PT appointment, we will do our best to accommodate your preferred time and date.

Cancellation Lists

If you are unable to book an appointment at your preferred time, please request to have your name placed on our cancellation list for the date and time of your choice. You will be contacted if the time becomes available.

Cancelling a Pilates Appointment

If you cancel a Pilates appointment less than 24 hours prior to your scheduled time, you are subject to a late cancellation fee equivalent to the full session rate. This applies to Private, semi-private, and group classes.

We Want To Hear From You!!

Please take any opportunity to let us know how we can better serve you and make you experience at Core more enjoyable. We have provided customer comment boxes at both of our locations or complete our online survey at http://www.surveymonkey.com/s.aspx?sm=tGlKf8sCGxOCy_2b0AJPhxxA_3d_3d if you would prefer to stay anonymous.

Make Pilates A Part of Your Life!

For a more detailed list of frequently asked questions, class schedules or more information about the services we offer, Please visit us on the web at:

www.coreconditioningpt.com

Understanding the Billing Process

Billing Facts

Know your insurance plan's coverage provisions and requirements. Be sure to read your benefits handbook and question your insurance company on any areas that are unclear.

Price quotes for services are estimates only. Your final bill will reflect your total charges, monies paid and any outstanding balances due.

Our billing and insurance liaison is available Monday through Friday from 8:30am – 5:00pm. Please feel free to call with any questions or concerns at 818 907-0008

Medicare

We bill Medicare and your secondary insurance following receipt of Medicare's payment. Once your secondary insurance has been billed, you will receive periodic statement advising you of the balance due.

Private Insurance

We will bill your contracted insurance carrier. You will not be billed while the claim is in process. Upon receipt of their payment or denial, we will bill you for co-insurance, deductibles and non-covered services based on your responsibilities established by your insurance provider

Cash

For patients who wish to pay for physical therapy services directly, make payment at the time services are rendered.

Balance Billing-Patient Responsibility

If you are unable to pay for your portion of your bill in full, please contact us to arrange mutually acceptable payment options.

New Patient Form

| | | | |
|--|--------------------------------|--|----------------------------|
| Date: | | Evaluating Therapist: | |
| First Name: | Last Name: | Middle Init.: | |
| Home Address | | | |
| City | | State | Zip Code |
| Home Phone: () - | Work Phone: () - | Other Phone: () - | |
| Social Security: - - | Birthdate: / / | Age: | Sex: M / F |
| Driver's License: | | Email Address: | |
| Status: Married / Single / Divorced / Separated / Widowed | | Student: No / Full-time / Part-time | |
| Emergency Contact: | Relationship: | Phone: () - | |
| Employer: | | Employment: Full / Part / Not Working / Retired | |
| Address: | | Phone: () - | |
| Doctor: | | Phone: () - | |
| Address: | | | |
| Whom, other than your doctor, may we thank for your referral? | | | |
| Injury Type: Work / Auto / Home / Other: | | | Injury Date: / / |
| Area(s) Being Treated: | | | |
| Claim / Authorization / Referral #: | | Lawyer Involvement: Yes / No | |
| Attorney: | Phone: () - | Fax: () - | |
| Attorney's Address: | | | |
| Primary Insurance: | | | |
| Insured's Name: | Social Security: - - | D.O.B.: / / | |
| Secondary Insurance: | | | |
| Insured's Name: | Social Security: - - | D.O.B.: / / | |
| Patient Signature | | Date | |

Medical History Form

Patient Name: _____ DOB: _____ Age: _____

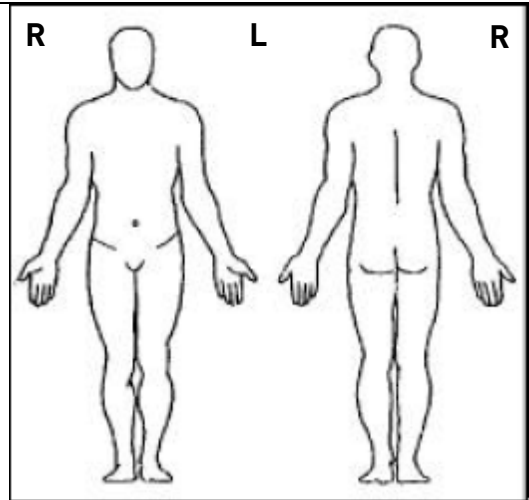
Injury / Condition: _____

Date of Injury / Onset: _____

Type of Surgery & Date: _____

Next Doctor's Appointment: _____

Previous Treatment: _____



Have you ever had any imaging performed?

- | | |
|-------------------------------------|----------------------------------|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> MRI |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Doppler |
| <input type="checkbox"/> Ultrasound | |

Have you recently noted any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Pregnancy/IUD | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Cramps when walking | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Change in Vision/Hearing | <input type="checkbox"/> Insomnia |

Do you have now, or have you ever had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Circulation Problems/Clots | <input type="checkbox"/> Easy Bruising/Bleeding | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Leg/Ankle Swelling | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Urinary Problems/Infections | <input type="checkbox"/> Allergies/Skin Sensitivity |

Explain and give approximate dates for any items indicated above.

Are you currently taking any medications? Yes / No Name/Type of Medication: _____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other: _____

Rate your pain (average) on a scale of 1 to 10 (1=light, 10=severe) _____

What do you hope to get out of your treatment? _____

What are your physical or fitness goals?

Currently: _____

In 6 Months: _____

In 12 Months: _____

Is there anything else you would like to include or ask your physical therapist? _____



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Consent Form

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by evaluation examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities: and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed with the clinical setting, your communication with family and friends may be restricted. Core Conditioning reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I _____ , agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read the consent form and authorize release of medical information to appropriate third parties.

Patient Signature _____ Date _____

Office Policy

CONSENT FOR CARE & TREATMENT Your physical therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Core Conditioning** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize **Core Conditioning** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered you.

CANCELLATION & NO-SHOW POLICY We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$75 for physical therapy visits and the full price for a massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

FINANCIAL POLICY We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made at each visit. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit \$ _____

Arrangements for payment of patient's co-pay / deductible amount (circle one)

I will pay each visit

I will pay weekly in advance

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. *Core Conditioning reserves the right to refuse service to anyone.*

Patient / Guardian / Responsible Party Signature

Date

Clinic Representative

Date

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Core Conditioning to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian 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.

USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose medical information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose medical information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required by Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice, and will post the current notice in our facility.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. **Other Uses of Medical Information:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

By my signature below, I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature

Date



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CANCELLATION & NO-SHOW POLICY

We require **24 hours notice** in the event of a cancellation. It is your responsibility, when you call, to have an alternative time in mind to insure that you will receive the prescribed number of treatments.

There is a \$75 charge for cancellation without proper notice (24 hours).

This charge will not be covered by insurance or lien, but must be paid by you personally prior to receiving additional treatment. If you're having physical therapy massage or private Pilates session, and cancel without proper notice, you are responsible for full price of services.

Thank you for your cooperation. **Core Conditioning** is looking forward to your speedy recovery.

I have read this document and fully understand my responsibilities.

Patient Signature

Date



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Dear Valued Customer,

Core Conditioning requires a current prescription (RX) signed by a Doctor in order to treat you for physical therapy. As a courtesy to you, Core Conditioning will provide a blank RX for you to take to your treating Doctor. Please have your prescription signed and bring it with you to your next appointment.

Please understand that we need a current RX in order to bill your insurance company. In the event that your insurance does not pay for services rendered, you will be responsible for outstanding balances and/or obtaining a back dated RX.

Core Conditioning would like to thank you in advance for your cooperation.

Patient Signature _____ Date _____



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Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

| | Completely Disagree | | | Unsure | | Completely Agree | |
|---|---------------------|---|---|--------|---|------------------|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| My pain was caused by physical activity | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *Physical activity makes my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *Physical activity might harm my back | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *I should not do physical activities which (might) make my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *I cannot do physical activities which (might) make my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

FABQ(PA) Score: _____ Greater than 19 Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or would affect your back.

| | Completely Disagree | | | Unsure | | Completely Agree | |
|---|---------------------|---|---|--------|---|------------------|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *My pain was caused by my work or by an accident at work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *My work aggravated my pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I have a claim for compensation for my pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *My work is too heavy for me | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *My work makes or would make my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *My work might harm my back | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *I should not do my regular work with my present pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I cannot do my normal work with my present pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I cannot do my normal work until my pain is treated | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| *I do not think that I will be back to my normal work within 3 months | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I do not think that I will ever be able to go back to work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

FABQ(PA) Score: _____ Greater than 19 Less than 12 (For * questions only)