Physical Therapy
Pilates
RedCord™
Gyrotonic®

12930 Ventura Blvd., Ste 226A
Studio City, CA 91604
(818) 907.0008 phone
(818) 907 0008 fax
www.coreconditioningpt.com

2104 West Magnolia Blvd
Burbank, CA 91506
(818) 333.7281 phone
(818) 907 0008 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 $90 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.

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, deductible 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.

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

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New Patient Form

Date:		Evaluating Therapist:			
First Name:		Last Name:		Middle Init.:	
Social Security:		Driver's License:			
Birth date:		Age:	Height:	Weight:	Sex: M / F
Home Address:					
City:		State:		Zip Code:	
Mobile Phone:		Home Phone:		Work Phone:	
Email Address:					
Preferred method of contact: E-mail / Phone call					
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:					
Primary Insurance:					
Insured's Name:		Social Security:		D.O.B.:	
Secondary Insurance:					
Insured's Name:		Social Security:		D.O.B.:	

Patient Signature _____ **Date** _____

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Medical History Form

Patient Name: _____ DOB: _____ Age: _____

Weight: _____ Height: _____

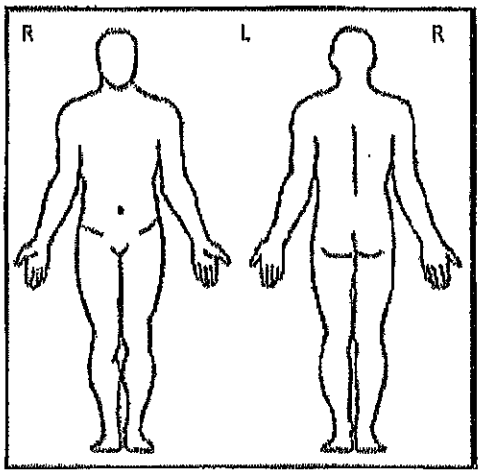
Injury / Condition: _____

Date of Injury / Onset: _____

Type of Surgery & Date: _____

Next Doctor's Appointment: _____

Previous Treatment: _____



Are you enrolled in Home Health Care? Y / N

Have you ever had any imaging performed?

☐ X-Ray ☐ Ultrasound ☐ Doppler
☐ CT Scan ☐ MRI

Have you recently noted any of the following?

☐ Weight Loss/Gain ☐ Weakness ☐ Pregnancy/IUD ☐ Pain at Night
☐ Nausea/Vomiting ☐ Fever/Chills/Sweats ☐ Cramps when walking ☐ Headaches
☐ Fatigue ☐ Numbness/Tingling ☐ Change in Vision/Hearing ☐ Insomnia

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

☐ Surgeries ☐ Sprains/Strains ☐ Heart Problems
☐ Circulation Problems/Clots ☐ Easy Bruising/Bleeding ☐ Indigestion/Heartburn
☐ Loss of Consciousness ☐ Diabetes ☐ Cancer
☐ Asthma/Breathing Problems ☐ Leg/Ankle Swelling ☐ Fainting
☐ Fractures ☐ Blood Pressure Problems ☐ Motor Vehicle Accident
☐ Lung Disease ☐ Urinary Problems/Infections ☐ Allergies/Skin Sensitivity

Explain and give approximate dates for any items indicated above: _____

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? _____

Patient Consent for Treatment, Payment, and Healthcare Operations

We would like to THANK YOU for choosing Core Conditioning, Inc.

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by Core Conditioning, Inc. I authorize Core Conditioning, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic or other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue Core Conditioning, Inc., any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses, or damages on account of injuries, including death or damage to property, caused, or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

I have the right to designate a close friend or family member to act in matters that relate to my treatment. I hereby authorize and designate the following individual to act in all matters in connection with my treatment by Core Conditioning, Inc., including, without limitation, discuss my therapy plan of care, and schedule and cancel my appointments:

First and Last Name	Phone Number	Relationship to Patient

PAYMENT AND FINANCIAL AGREEMENT

Core Conditioning, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment. I certify that the information I have given about my insurance coverage or other payment source is correct.

FINANCIAL RESPONSIBILITY

I understand that in some instances my health insurance may not cover all treatment charges incurred. I agree to be financially responsible to Core Conditioning, Inc. for any medically necessary therapeutic services that are not covered by my health insurance carrier. In addition, I authorize Core Conditioning, Inc. to release (a) any medical or other information about Core Conditioning, Inc. services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments; (b) any medical or other information required by my insurer, other payers and their agents; and (c) medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

Patient Consent for Treatment, Payment, and Healthcare Operations

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Core Conditioning, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by Core Conditioning, Inc. for treatment. By way of my signature below, I provide Core Conditioning, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices. CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following Core Conditioning, Inc. policy to reduce the balance billed to me at the end of care: Copays are collected in full at the time of service. Balances towards deductible and coinsurance will be collected as insurance(s) processes claims throughout the course of treatment. Any outstanding balances due at the end of each month will be billed to the patient.

LITIGATION ACCOUNTS

With respect to litigation against another party, I understand that Core Conditioning, Inc. will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against another party will not enable me to refuse payment to Core Conditioning, Inc.. I fully understand that I am directly and fully responsible to Core Conditioning, Inc. for all medical bills submitted by Core Conditioning, Inc. for services rendered to me regardless of whether my claims are settled or result from a court judgment.

PATIENT VALUABLES I relieve Core Conditioning, Inc. of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that Core Conditioning, Inc. will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the Core Conditioning, Inc. Notice of Privacy Practices, either now or previously. _____ Patient Initials (Required)

- I give Core Conditioning, Inc. permission to use my information as described in the Core Conditioning, Inc. Notice of Privacy Practices.
- Core Conditioning, Inc. may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc.
- To the extent permitted under state and federal law, Core Conditioning, Inc. may access and share my medical and other information as is necessary for Core Conditioning, Inc. to provide treatment to me, seek payment for services it provides, or for Core Conditioning, Inc.'s own healthcare-related operations.
- I understand that Core Conditioning, Inc. may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or the provision of other treatment related healthcare services to me.
- I also give permission for Core Conditioning, Inc. to release patient and educational information to my home caregiver.
- I understand that my information may be released if required by local, state, or federal law.

Patient Consent for Treatment, Payment, and Healthcare Operations

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from Core Conditioning, Inc. for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that email communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting Core Conditioning, Inc. or utilizing the opt-out method that will be identified in the applicable communication.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)

I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR Core Conditioning, Inc. OFFICE USE ONLY

Verification of the identity of the above-named party was made by (check applicable):

- o Current Driver's License or other Photo ID
- o Current Health Insurance Card
- o Other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all Core Conditioning, Inc. facilities.

Signature of Patient or Guardian (if patient is a minor)	Date
Date Signature of Core Conditioning, Inc. Representative	Date

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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.

CANCELLATION & NO-SHOW POLICY.
We require **24 hours notice** in the event of a cancellation. The charge for cancellation without proper notice is **$65** for physical therapy visits and the full price for a massage or Pilates visit. This charge is not 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: $ _____

Arrangement for payment of patient's co-pay/deductible amount (circle one):
I will pay each visit ☐ **I will pay weekly in advance** ☐

Please provide your credit card information so that we may charge you for your balances not collected at the time of service. Credit card number: _____ **Expiration date:** _____

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:** _____

Client Representative: _____ Date: _____

CONSENT FOR TREATMENT OF A MINOR.

As a 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: _____

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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.

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/Guardian Signature _____ **Date** _____

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Medications List

*Please list all **prescription** medications you are currently taking. You may also bring a list for us to copy in the office.*

Name of Medication:

Dosage: Frequency

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

Name of Medication:

Dosage: Frequency

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

Name of Medication:

Dosage: Frequency:

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

*Please list all **over the counter medications and supplements** you are currently taking. You may also bring a list for us to copy in the office.*

Name of medication or supplement:

Dosage: Frequency:

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

Name of medication or supplement:

Dosage: Frequency:

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

Name of medication or supplement:

Dosage: Frequency:

How are you taking this medication? (Circle one): By Mouth / Injection / Patch / Lotion / Other

If other, explain:

Patient/Guardian Signature: **Date:**

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Core Conditioning Health Acknowledgement

By entering any Core Conditioning facility for any reason, I confirm that I:

1. Do not have a cough or shortness of breath
2. Do not have a fever, chills, repeated shaking with chills, muscle pain, headache, sore throat or new loss of taste or smell
3. Do not live with or have come in close contact with anyone exhibiting any signs of COVID-19 related illness, or anyone who has tested positive for COVID-19, or anyone who is suspected of having been exposed to COVID-19

This acknowledgement will remain in effect and may be relied upon by Core Conditioning any time I enter into one of their facilities. I will refrain from entering any Core Conditioning facility and **will notify Core Conditioning immediately** should anything change with respect to my acknowledgement of this information.

DATE

PRINT NAME

SIGNATURE (Patient/Client/Patient Representative)

_____ (Reviewed by Core Conditioning)
Employee Initial