# PURO

PHYSICAL THERAPY & SPORTS MEDICINE

**Whom may we thank for referring you?**

☐ Doctor__________ ☐ Family Member______

☐ Friend__________ ☐ Other______ ☐ Website_____________

| Last Name: | First Name: | Middle Name: |
|---|---|---|
| | | |

| Birth date: / / | Sex: ☐ Male ☐ Female | Age | Home Phone Number: | Cell Phone Number: |
|---|---|---|---|---|

| Street Address: | City: | State: | Zip: |
|---|---|---|---|

| Email Address: | Primary Care Physician: | Physician Phone Number: |
|---|---|---|

| Occupation: | Employer: |
|---|---|

## General Information

## Insurance Information

| Insurance carrier name: | Subscriber/Member ID:<br>Group # (if applicable): | Patient's relationship to Card Holder: |
|---|---|---|

| Insurance Card Holder's name: | Birth date: / / | Address of Card Holder: |
|---|---|---|

| Do you have a prescription:<br>Yes ☐ No ☐ | Prescription Date: | Prescription frequency/# of visits: |
|---|---|---|

| What is the injury/surgery: | Date of onset/date of surgery: |
|---|---|

| Previous treatment: |
|---|

**Patient/Guardian Signature: ___________________________Date: __________________**

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**Have you ever experienced any of the following conditions?** Patient Name:______________________________

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia/blood Disorder | | | Stroke | | | Sensitivity to Ice | | |
| Arthritis | | | Falls | | | Sensitivity to Heat | | |
| Bowel/bladder problems | | | Gynecologic Conditions | | | Lung Disorder | | |
| Cancer | | | Headaches (>1 per week) | | | Neurological Disorder | | |
| Depression | | | Hearing Problems | | | Osteoarthritis | | |
| Diabetes | | | Hernia | | | Osteoporosis | | |
| Dizziness | | | Kidney Problems | | | Rheumatologic Disorder | | |
| Arterial Blockage of Legs | | | Liver/Kidney Condition | | | Thyroid Condition | | |
| Deep Venous Thrombosis | | | Head Trauma | | | Vision Problem | | |
| Heart Disease | | | Fractures | | | Have a pacemaker | | |
| High Blood Pressure | | | Seizures | | | Have metal implants | | |

**Medications Currently Taking** **How much/how often**

**1.**

**2.**

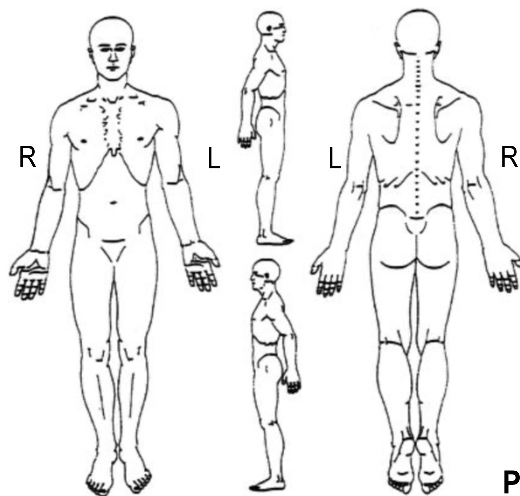
Please list any allergies you have-

Do you smoke? Yes No Alcohol consumption: daily weekly occasionally rarely never

Are you pregnant? Yes No Have you experienced recent unplanned weight loss? Yes No

Describe Diagnosis/Injury:

**Please mark the area of discomfort**




**Rate the intensity of the pain at its <u>best</u>**

(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

**Rate the intensity of pain at its <u>worst</u>**

(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

**Which description are you experiencing?**

Aching Numbness Stabbing

Burning Dull Pins and Needles

The above information is correct to the best of my knowledge.

**Patient/Guardian Signature:________________Date:___________**

PURO Physical Therapy & Sports Medicine

Tel: (310) 717-1909 · Fax: (310) 807-6385 · Email: admin@purophysicaltherapy.com

## 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 carefully.**

**PURO Physical Therapy, PC Legal Duty**

PURO Physical Therapy, P.C. is legally obligated to maintain the confidentiality and security of all protected health information ("PHI") in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws. All employees, contractors, and affiliated personnel are required to comply with these regulations and safeguard patient information at all times. Patients have the right to request, in writing, specific restrictions on how their PHI is used or disclosed for purposes of treatment, payment, or healthcare operations. No use or disclosure of patient information will occur beyond the permitted or required circumstances outlined below without the patient's prior written authorization.

**Uses and Disclosures of Health Information**

PURO Physical Therapy, P.C. uses your protected health information ("PHI") for treatment, payment, administrative operations, and quality assurance. We may contact you regarding appointments, treatment options, or health-related services.

We may also use or disclose your PHI without written authorization when required or permitted by law—such as in emergencies, approved research, audits, or public health reporting. In all other cases, we will obtain your written authorization before releasing your information, which you may revoke at any time in writing.

PURO Physical Therapy, P.C. may update this Notice at any time. Updated versions will be posted in our office and available upon request. You may request, in writing, specific restrictions on how your PHI is used or disclosed.

**Patient's Individual Rights**

As a patient of PURO Physical Therapy, P.C., you have the right to review and obtain a copy of your protected health information ("PHI") at any time, subject to applicable legal and administrative requirements. You also have the right to request amendments to your records if you believe any information is inaccurate or incomplete. In addition, you may request an accounting of disclosures identifying when your PHI has been shared for purposes other than treatment, payment, or healthcare operations.

You have the right to request, in writing, that PURO Physical Therapy, P.C. restrict the use or disclosure of your PHI for treatment, payment, or operational purposes, except when such use or disclosure is required by law or necessary in emergency situations. While PURO Physical Therapy, P.C. will review and consider all such requests on a case-by-case basis, the practice is not legally obligated to agree to any requested restrictions.

**Treatment of a Minor**

I, as a parent/guardian of a minor receiving physical therapy treatment do agree and understand that I have been advised to remain on the premises during physical therapy treatment and waive any claim I may have resulting from failure to do so.

**Concerns and Complaints**

If you are concerned that we 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 Privacy Officer 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 our health information practices or if you have a complaint regarding HIPAA regulations, please contact Dr. Preston Poole, PT, DPT.

*****PLEASE RETAIN THIS COPY FOR YOUR RECORDS*****

PURO

PHYSICAL THERAPY &
SPORTS MEDICINE

**Patient Consent/Disclosures to Health Information**

I have read and understand the *PURO Physical Therapy, P.C. Notice of Information Practices.* I consent to physical therapy treatment and acknowledge that PURO Physical Therapy, P.C. may use or disclose my protected health information ("PHI") for treatment, payment, quality assurance, and administrative operations. I understand that any request to restrict the use or disclosure of my PHI will be considered on a case-by-case basis, but the practice is not required to agree to such requests.

* *I hereby consent to the use and disclosure of my protected health information ("PHI") as described in the* PURO Physical Therapy, P.C. Notice of Information Practices. *I understand that I may revoke this consent in writing at any time, except to the extent that the practice has already acted in reliance on it.*

**Patient Insurance Responsibility**

As a courtesy, PURO Physical Therapy, P.C. will verify your insurance benefits; however, any quoted coverage or payment estimate is based on information provided by your insurance company and is not a guarantee of payment. Final claim processing may result in higher or lower patient responsibility. Patients are encouraged to verify their own benefits prior to beginning treatment.

All co-pays, co-insurance, deductibles, and cash service fees are due at the time of service. Patients acknowledge that if they are receiving therapy from another provider, including home health services, or have not been formally discharged, they will be personally and fully responsible for all charges incurred at PURO Physical Therapy, P.C.

* *I authorize all insurance benefits, including private, Medicare, and Workers' Compensation, to be paid directly to PURO Physical Therapy, P.C. for services rendered. I understand that if my insurance denies, limits, or does not cover payment for any portion of my treatment, I am personally and fully responsible for all charges incurred.*

**Credit Card Payment Authorization – Patient / Customer Initiated**

PURO Physical Therapy, P.C. uses secure, tokenized software to store credit card information for future payments. I authorize PURO Physical Therapy, P.C. to charge my card for all services, products, and fees related to my account. This authorization remains in effect until I cancel it in writing. I agree to notify the clinic of any account changes and certify that I am an authorized user of the card. All transactions will comply with applicable U.S. laws.

**Late cancellation/No-show Fee**

We request that you notify us by phone or text at (310) 717-1909 or email at admin@purophysicaltherapy.com, at least 24-hours prior to your scheduled appointment. If you fail to keep your appointment or do not cancel 24-hours prior to your appointment time, you will be subject to a **$45 late cancellation/no-show fee**.

**I understand the terms of this form and hereby state that I am financially responsible for charges incurred from cancellations or no shows, as well as take insurance responsibility.*

**Patient Name** ________________________________________________

**Patient/Guardian Signature:** ______________________________ **Date** __________