FITNESS PHILOSOPHY, LLC.
23067 VENTURA BLVD. SUITE A
WOODLAND HILLS, CA 91364
(818) 223-9985 (818) 223-9986 FAX

Note: the patient must complete all items on this form. Write N/A if question is not applicable.

Patient Information:

Last Name: _____
First Name: _____
Address: _____
City: _____
State: _____ ***Zip:*** _____
Home Phone: _____
Cell Phone: _____
Social Security #: (Required) _____
Email Address: _____
Driver's License #: _____
Sex: M / F Date of Birth: _____/_____/_____
Referring Dr.: _____
Date of Injury/Surgery: _____
Injury is due to: _____
Accident (Auto/ Other)/Work Related/ Personal Injury/Illness

Employer:

Company: _____
Job Title: _____
Address: _____
City: _____
State: _____ ***Zip:*** _____
Business Phone: _____
Date Last Worked: _____

Spouse's Information:

Name: _____
Address: _____
Phone: _____
Social Security #: _____
Driver's License #: _____

How were you referred to Fitness Philosophy? □ Physician □ Friend/Family Member □ Internet or Website □ Other Please Explain or List Website or Name of Friend/Family Member: _____

Responsible Party (if other than patient):

Last Name: _____ ***First Name:*** _____
Address: _____ ***City, State, Zip:*** _____
Phone Number: _____ ***Relationship to Patient:*** _____

Insurance Policy # 1:

Name of Ins. Co.: _____ ***Name of Policy Holder:*** _____
Policy Holder's Date of Birth: _____/_____/_____ ***Relationship to Policy Holder:*** Self /Spouse/Child/Other
ID#: _____ ***Group #:*** _____
Phone #: _____ ***Adjuster:*** _____

Insurance Policy # 2:

Name of Ins. Co.: _____ ***Name of Policy Holder:*** _____
Policy Holder's Date of Birth: ____/_____/_____ ***Relationship to Policy Holder:*** Self/Spouse/Child/Other
ID#: _____ ***Group #:*** _____
Phone #: _____ ***Adjuster:*** _____

Attorney:

Name: _____ ***Phone Number:*** _____
Address: _____ ***City, State, Zip:*** _____

I HEREBY AUTHORIZE FITNESS PHILOSOPHY, LLC. TO FURNISH MY INSURANCE CARRIER(S) ANY AND ALL REQUESTED INFORMATION CONCERNING MY HEALTHCARE. I AUTHORIZE MY INSURANCE CARRIER(S) TO PAY FITNESS PHILOSOPHY, LLC. DIRECTLY FOR SERVICES RENDERED. I UNDERSTAND THAT I SHALL BE PERSONALLY LIABLE FOR ANY UNPAID BALANCE. I HEREBY AUTHORIZE FITNESS PHILOSOPHY, LLC. TO RELEASE ANY INFORMATION CONCERNING MY MEDICAL RECORDS. I UNDERSTAND THAT IF SUIT IS FILED TO COLLECT ANY OUTSTANDING BALANCE, THE UNDERSIGNED AGREES TO PAY ALL COSTS OF SAID ACTION TOGETHER WITH REASONABLE ATTORNEY'S FEES. THE UNDERSIGNED ACKNOWLEDGES THAT THIS AGREEMENT IS ENTERED INTO AND IS TO BE PERFORMED IN THE COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AND FURTHER AGREES THAT ANY ACTION TO ENFORCE THIS AGREEMENT SHALL BE FILED AT A COURT OF THE CHOICE OF FITNESS PHILOSOPHY, LLC. THE UNDERSIGNED HEREBY WAIVES THE PLEADING OF THE STATUTE OF LIMITATIONS AS A DEFENSE TO THIS OBLIGATION.

PATIENT'S SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): _____ **DATE:** _____

FITNESS PHILOSOPHY

Patient Information and Brief History

Patient name:_____ Date:_____

Parent or Guardian (if minor):_____

Emergency Contact:_____ Phone:_____

Family Dr.:_____ Phone:_____

Specialist Dr.:_____ Phone:_____

Reason For Visit: _____

Date of Injury / Surgery:_____

Please check any conditions which you have currently or had in the past.

Allergy	____	Fever	____	Seizures	____
Arthritis	____	Headaches	____	Smoke Cigarettes	____
Asthma	____	Head injury	____	Stomach Pain	____
Bowel/Bladder Problems	____	Hearing Loss	____	Stroke	____
Cancer	____	Heart Ailments	____	Sudden Weight Loss	____
Cirrosis	____	Hepititus	____	Tremor	____
Depression	____	Hernia	____	Tuberculosis	____
Diabetes	____	High Blood Pressure	____	Ulcer	____
Dizziness	____	Kidney Infection	____	Other: _____	
Emphysema	____	Metal Implants	____	_____	
Eye Problems	____	Nervous Disorder	____	_____	
Fainting	____	Pacemaker	____	_____	

Please explain (if appropriate):_____
_____

List any operations you have had and dates: _____
_____

List any major injuries you have had and dates:_____
_____

List all medications you are currently taking: _____
_____

List any medications to which you are allergic:_____
_____

Women: Date of last menstrual period:_____ Are you pregnant: Yes_____ No_____

Do you require social service intervention? Yes_____ No_____

The undersigned acknowledges and agrees that the information set forth herein is true and correct.

Date:_____ Patient: _____

PAIN DIAGRAM AND PAIN RATING

Name:_____ Date: _____/_____/_____
mm dd yy

Please use the diagram below to indicate the symptoms you have experience over the past 24 hours.
Be VERY precise when drawing the location of your pain. Use the key to indicate the type of symptoms

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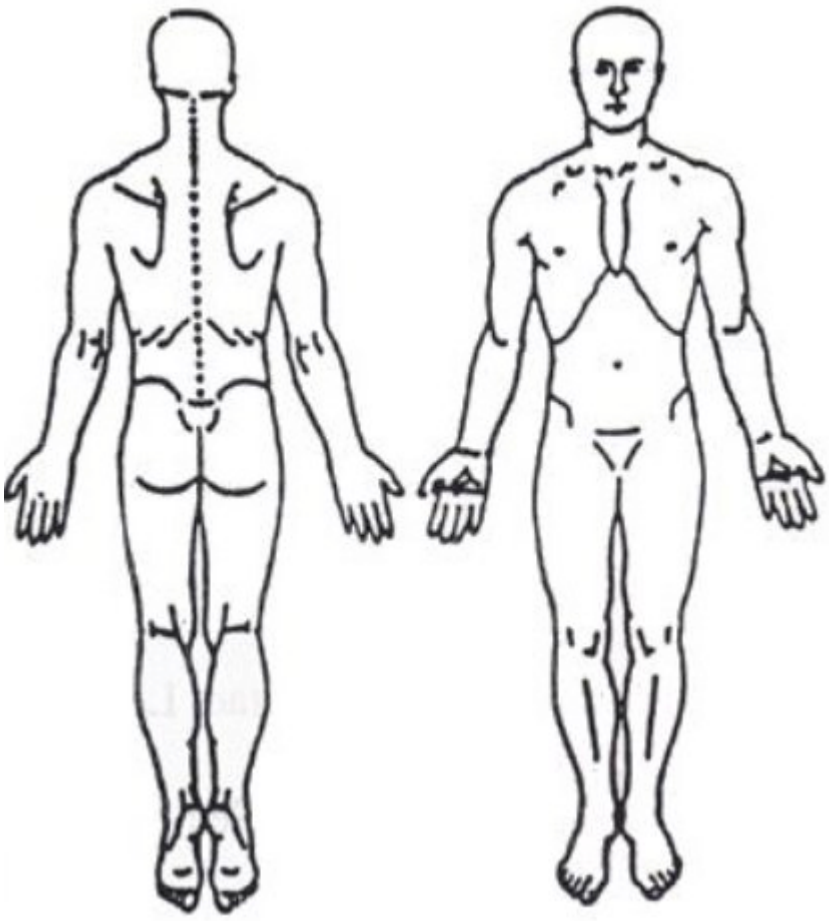
Key: Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

FITNESS PHILOSOPHY, LLC
23067 VENTURA BLVD. SUITE A
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(818)223-9985

APPOINTMENT POLICY

1) FOR YOUR APPOINTMENTS, PLEASE BRING OR WEAR CLOTHING THAT YOU WILL FEEL COMFORTABLE EXERCISING IN. FOR EXAMPLE: SHORTS, SWEAT SUITS, TENNIS SHOES, ETC.

2) IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE NOTIFY US **AT LEAST 24 HOURS IN ADVANCE** OF YOUR SCHEDULED APPOINTMENT TO CANCEL.

PRIVATE INSURANCE OR PERSONAL INJURY PATIENTS:- **IF YOU FAIL TO KEEP YOUR VISIT AS SCHEDULED WITHOUT NOTIFYING US AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE CHARGED $25.00 FOR EACH APPOINTMENT MISSED**. 3RD PARTY PAYERS DO NOT PAY FOR THIS VISIT. NEITHER YOUR INSURANCE COMPANY NOR YOUR ATTORNEY WILL BE RESPONSIBLE FOR THIS FEE. THEREFORE, IN THAT CIRCUMSTANCE YOU WILL BE RESPONSIBLE FOR THE FEE. WE CAN BE REACHED BY VOICEMAIL 24 HOURS A DAY.

WORKERS COMPENSATION PATIENTS:- IN ORDER TO PREVENT TERMINATING YOUR WORKERS COMPENSATION BENEFITS YOU MUST RECEIVE ALL OF THE PHYSICAL THERAPY ORDERED BY YOUR DOCTOR. WE ARE REQUIRED TO CONTACT YOUR EMPLOYER, ATTORNEY OR INSURANCE COMPANY IF YOU FAIL TO KEEP YOUR APPOINTMENTS.

3) YOU WILL BE RESPONSIBLE FOR SCHEDULING YOUR APPOINTMENTS FOR THERAPY ON A WEEKLY BASIS. PLEASE SCHEDULE THERAPY APPOINTMENT **AT LEAST ONE WEEK IN ADVANCE.**

DO NOT ASSUME THAT YOU ARE SCHEDULED!

4) IT IS IMPORTANT THAT EVERYONE BE ON TIME FOR THEIR APPOINTMENT! IF YOU ARE MORE THAN 15 MINUTES LATE, YOUR THERAPIST MAY NOT BE ABLE TO TREAT OR MAY BE ABLE TO ADMINISTER ONLY PART OF YOUR TREATMENT DUE TO HEAVY PATIENT SCHEDULING.

5) PLEASE INFORM THE THERAPISTS IN ADVANCE OF ANY APPOINTMENTS YOU MAY HAVE WITH YOUR PHYSICIAN SO WE MAY PREPARE A PROGRESS REPORT FOR HIM/HER.

6) PLEASE BRING A PHYSICAL THERAPY PRESCRIPTIONS FROM YOUR PHYSICIAN ON A MONTHLY BASIS. IF YOU HAVE NOT BEEN TREATED FOR THERAPY IN OVER A MONTH, WE WILL NEED A NEW PRESCRIPTION FROM YOUR PHYSICIAN IN ORDER TO TREAT YOU.

I HAVE READ , UNDERSTAND, AND AGREE WITH THE ABOVE APPOINTMENT POLICY ADMINISTERED BY FITNESS PHILOSOPHY, LLC.

_____ _____

PATIENT SIGNATURE DATE

Fitness Philosophy, LLC

Informed Consent for Physical Therapy

Dear Patient:

There are benefits and risks to any and all forms of medical treatment, including physical therapy. Physical therapy involves many types of treatments, procedures and modalities. The physical response and reaction to different types of medical therapies can vary widely from patient to patient. It is not possible to predict each patient's response to a specific therapy modality. Additionally, we are not able to guarantee what your specific reaction to and outcome from physical therapy may be.

You have the right to question or inquire of your treating physical therapist what specific type of treatment he or she is planning based on your diagnosis and symptoms. Your therapist is happy and able to explain the type of treatment planned for you and what the potential risks, if any, might be. You have a right to decline any portion of your treatment at any time before or during the physical therapy treatment.

Therapeutic exercise is an integral part of most physical therapy treatment plans. As you may or may not know, any and all exercise has inherent physical risks associated with it. If you have any questions regarding the types of exercise you are performing and any specific risks associated with them, the therapist will be glad to answer them.

I consent to treatment by Fitness Philosophy, LLC and acknowledge that I understand the benefits and risks of physical therapy treatment.

_____
Patient Name

_____ _____
Signature Date

Fitness Philosophy, LLC

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

Fitness Philosophy, LLC's LEGAL DUTY

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

Uses and Disclosures of Health Information

Fitness Philosophy, LLC uses your health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Fitness Philosophy, LLC 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.

Fitness Philosophy, LLC 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 requested by law.

In any other situation, Fitness Philosophy, LLC'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.

Fitness Philosophy, LLC 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 your Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to obtain a copy of your personal health information. Fitness Philosophy, LLC shall not have less than 48 hours from the date of your written request to prepare and copy your medical records. The fee for copying is $15.00. 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 emergency circumstances. Fitness Philosophy, LLC 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 Fitness Philosophy, LLC may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosed 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 Fitness Philosophy, LLC's health information practices or if you have a complaint, please contact:

Fitness Philosophy, LLC
Jason Shano
23067 Ventura Blvd. Suite A
Woodland Hills, CA 91364
(818) 223-9985 TEL (818) 223-9986 FAX

Fitness Philosophy, LLC

Patient Information Consent Form

I have read and I full understand Fitness Philosophy, LLC's notice of Information Practices. I understand that Fitness Philosophy, LLC 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 Fitness Philosophy, LLC will consider requests for restrictions on a case by case basis, but does not agree to request for restrictions.

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

_____
Patient Name

_____ _____
Signature Date

Authorization To Release Medical Information

In the event we need medical information from your Doctor in the course of your treatment, please sign the medical information release below:

My signature authorizes my referring physician to provide Fitness Philosophy, LLC with my personal medical information in order that my Physical Therapist may provide more appropriate treatment.

_____
Patient Name

_____ _____
Signature Date