Welcome to Pukka Pilates & Physical Therapy and thank you for choosing us as your partner in health and fitness. Our entire staff is committed to providing our patients with the highest quality care.

POLICY INFORMATION

The enclosed materials are Patient-Physical Therapy Disclosure Documents for Pukka Pilates and Physical Therapy, Inc., d/b/a Pukka Pilates & Physical Therapy ("PUKKA"). These documents are reviewed and updated frequently. Before proceeding with any physical therapy treatment, you are encouraged to read the enclosed documents and provide relevant information, as well as signatures acknowledging receipt, understanding, and any permissions or consents being requested.

If you should ever have any information regarding these Patient-Physical Therapy Disclosure Documents, please contact us at the numbers listed below at the close of each page.

CONSENT FOR PHYSICAL THERAPY

Please print all pages, fill out, sign and bring with you to your first appointment.

1. **Physical therapy.** In the state of California, physical therapists can see you without a medical referral, for wellness and fitness purposes, and for an initial physical therapy evaluation. However, for physical therapy treatment of an injury, you will need a diagnosis or referral from a medical doctor or chiropractor before we can administer treatment. **I understand PUKKA will not provide physical therapy treatment for a specific injury without a diagnosis or referral**.

2. **Insurance.** We are an out-of-network provider. **I understand that PUKKA's physical therapy services are billed to the patient and that full payment is due at the time of service**.

3. **Medicare.** In order for a patient who has Medicare to be treated by Pukka Pilates and Physical Therapy, Inc. the patient must first verify:

    a) Services are non-covered because they are not defined as a Medicare benefit under the statute;
    b) Services are non-covered because they are not considered "reasonable and necessary";
    c) Services that may be a Medicare benefit are not covered because coverage requirements are not met and would result in a technical denial.

    I have verified that physical therapy services are not covered under the Medicare program and understand an Advanced Beneficiary Notice may need to be issued prior to treatment. **I understand that PUKKA's physical therapy services are billed to the patient and that full payment is due at the time of service.**

4. **Informed consent for treatment.** The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. PUKKA provides a wide range of services. **I understand that I will receive information from PUKKA at the initial visit concerning the treatment and options available for my condition.**

5. **Potential benefits.** Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. Nevertheless, benefits are not guaranteed nor guaranteed to be permanent. **I understand that PUKKA does not provide a guarantee and that potential benefits may be temporary.**

6. **Potential risks.** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. **I understand that it is my obligation to keep PUKKA informed of my present condition and any unanticipated pain or discomfort as a result of physical therapy.**

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7. **No warranty**. My physical therapist at PUKKA will share with me his or her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. **I understand that my physical therapist at PUKKA cannot and will not make any promises or guarantees regarding a cure for or improvement in my condition.**

8. **Alternatives.** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. **I understand that PUKKA will not endorse, recommend, or suggest any alternative, and any discussion or acquiescence thereof is not to be interpreted as an endorsement, recommendation, or suggestion.**

9. **Cancellation Policy.** PUKKA requires that appointment cancellations be made within 24 hours. **There is a full $65 service fee for no-shows or cancellation without proper notice.** If I cancel my physical therapy appointment without proper notice or no-show, I agree to pay the $65 service fee.

THE UNDERSIGNED ACKNOWLEDGES HAVING READ AND UNDERSTOOD THE ABOVE INFORMATION. THE UNDERSIGNED HEREBY CONSENTS TO PHYSICAL THERAPY EVALUATION AND TREATMENT BY PUKKA. I THE UNDERSIGNED ALSO ACKNOWLEDGES HE OR SHE WILL ABIDE BY THE CONDITIONS AND POLICIES NOTED ON THIS CONSENT FORM.

Name (Please Print) Signature Date

If signing on behalf of a patient as a Guardian, Agent, or other Legal Representative:

Name (Please Print) Signature Date

Relationship (if Applicable)

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PATIENT INFORMATION

Personal Information

Client/Patient: _____

Date of Birth: _____Age: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Do we have permission to leave messages with information about your appointments or treatments (yes/no):

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Email Address: _____

Emergency Contact: Name: _____Phone #: _____

Address: _____

Relationship: _____

Employment Information

Employer Name: _____

Employer Address: _____

Occupation (Industry): _____

Occupation (Position): _____

Therapy Information

Your goals for physical therapy: _____

How did you hear about us? _____

Were you referred to a particular practitioner? If so, who? _____

Referring Physician: _____Phone #: _____

Address: _____

When do you see your physician again? _____

Primary Care Physician: _____Phone #: _____

Type of Injury/Condition: _____Onset/Injury Date: _____

Physical limitations due to injury: _____

What activities aggravate your symptoms? _____

Type of Surgery & Date: _____

Describe any previous treatment for this condition: _____

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Have you had any diagnostic tests for this condition?

X-ray CT scan MRI Doppler Ultrasound

Please describe your pain: Sharp / Burning / Aching /

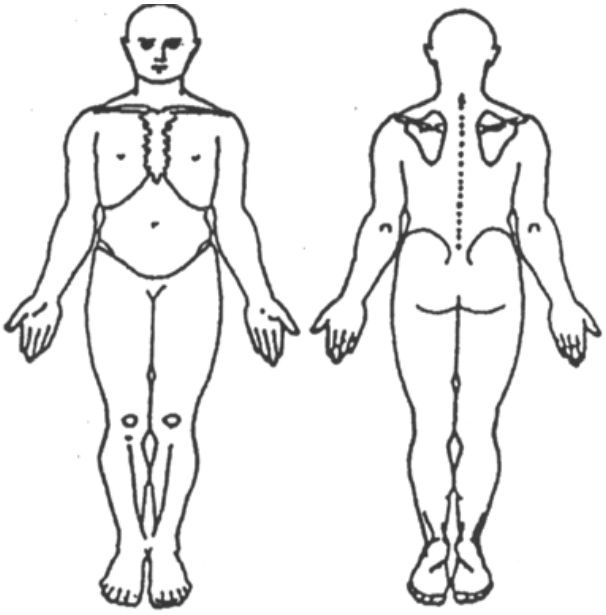
Tingling / Numbness / Other: _____

Please rate your pain (0 = none, 1 = minimal, 10 = severe):

At present: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10



Please mark the location of your symptoms

Are you currently taking medications? Yes / No. Please list meds:

_____

_____

Have you recently noted any of the following?

☐ Breathing Difficulty
☐ Change in Vision
☐ Fatigue
☐ Fever/Chills/Sweats
☐ Headaches
☐ Insomnia
☐ Nausea/Vomiting
☐ Pain at Night
☐ Pregnancy
☐ Weakness
☐ Weight Loss

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

☐ Allergies/Skin Sensitivity
☐ Asthma/Breathing Problems
☐ Autoimmune Deficiency
☐ Cancer
☐ Circulation Problems
☐ Diabetes
☐ Easy Bruising/Bleeding
☐ Fainting
☐ Fractures
☐ Heart Problems
☐ Hepatitis
☐ High Blood Pressure
☐ Indigestion/Heartburn
☐ Kidney Disease
☐ Leg/Ankle Swelling
☐ Loss of Consciousness
☐ Lung Disease
☐ Metal Implant
☐ Motor Vehicle Accident
☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia
☐ Sprains/Strains
☐ Stroke
☐ Surgeries
☐ Thyroid Problems
☐ Urinary Problems/Infections

☐ Any previous injury that may affect current care? Please describe: _____

Please explain & give approximate dates for any conditions marked above.

_____

_____

_____

Insurance Information

Primary Insurance: _____ | _____PPO | ____HMO | ____Other

Policyholder Name: _____ DOB: _____

Policyholder Address: _____

Policyholder Phone No. _____ Relationship: _____

Litigation Information

Attorney's Name_____ Phone No.: _____

Attorney's Firm's Name: _____

Firm's Address: _____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the following is offered for your information and consent. Please be aware that it is PUKKA's policy to require your reading and signing of this consent form prior to treatment.

- I authorize PUKKA to use and disclose my individual identifiable health information ("Health Information") for the express and sole purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered and/or engaging in health care operations.

- I understand that PUKKA's Notice of Privacy Practices describes in more detail the types of uses and disclosure of Health Information. I understand that I have the right to review such Notice priorto signing.

- I understand that I have the right to request a restriction on the use or disclosure of my Health Information. I further understand that PUKKA is not obligated to agree to my request. I have the right to revoke this consent at any time and in writing.

- I consent to and authorize PUKKA to administer all treatments and services that may be considered advisable in the judgment of my physician and/or physical therapist in accordance with PUKKA's policies.

- I understand that if I choose not to sign this consent, PUKKA may withhold medical services.

THE UNDERSIGNED ACKNOWLEDGES THAT HE/SHE HAS RECEIVED A COPY OF PUKKA'S NOTICE OF PRIVACY PRACTICES AND HAS READ THIS CONSENT TO USE AND DISCLOSE HEALTH INFORMATION.

Name (Please Print)	Signature	Date

If signing on behalf of a patient as a Guardian, Agent, or other Legal Representative:

Name (Please Print)	Signature	Date

Relationship (if Applicable)

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

This Notice describes how medical information about you may be used or disclosed and about how you can get access to information. Please review it carefully.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The HIPAA Privacy Rule gives individuals a fundamental right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their Personal Health Information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

PUKKA PHYSICAL THERAPY'S LEGAL DUTY

PUKKA is required by law to protect the privacy of your Personal Health Information (PHI), provide this Notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

PUKKA uses your Personal Health Information (PHI) primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may use your PHI to seek payment from your health insurance or from other sources of coverage such as automobile insurance. Your insurance company may request and receive information on dates of service, treatment provided, and the medical condition being treated. Staff members may use your PHI to evaluate your health and provide treatment. For example, treatment notes in your medical records will be available to all health care professionals who may provide treatment to you or who may be available to all health care professionals who may provided treatment to you or who may be consulted by our staff.

PUKKA may use your PHI to contact you to provide appointment reminders, information about your treatment alternatives, or other health related benefits that could be of interest to you.

PUKKA may also use or disclose your PHI without prior authorization for public health purposes, for government auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, PUKKA's policy is to obtain your written authorization to disclose your PHI. This authorization can be revoked at any time upon written notice.

PUKKA may change its policy at any time. A new **NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES** will be posted in the waiting room when changes are made. You may request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your Personal Health Information (PHI) at any time.

You have the right to request that we correct any inaccurate or incomplete information in your records.
You have the right to request a list of instances where we have disclosed your PHI for reasons other than treatment, payment or other related administrative purposes.

You have the right to request in writing that we do not use or disclose your PHI for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. PUKKA 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 PUKKA may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosures of your Personal Health Information (PHI), please contact our office immediately at Pukka Pilates & Physical Therapy, 12030 Scripps Summit Drive, Suite E, San Diego, CA 92131; (858) 271-8800.

You may also send a written complaint to the U.S. Department of Health and Human Services. Please visit their website at www.hhs.gov/ocr/privacy.