Atala Physical Therapy
Grey Hawk Business Center
3222 Grey Hawk Court
Carlsbad, CA 92010
P: (760) 727-9100
F: (760) 727-9122

What To Expect At Your First Visit

Atala Physical Therapy will redefine your patient care experience.
We aim to excel in service and experience. We strive to exceed your expectations!

What to Wear on Your First Visit?

Please wear comfortable and athletic clothing. Closed toe shoes, preferably tennis shoe/sneaker. Please arrive 15 minutes early to your scheduled appointment to complete all required paperwork and answer any questions you may have.

What Should I Bring?

- Completed paperwork
- Insurance card
- Physician's prescription for physical therapy, if you have one
- Medication List
- Recent imaging (X-Ray, MRI), if you have any

What Happens During My First Visit at Atala Physical Therapy?

Your first visit will last approximately 60-75 minutes. This will be an in-depth one on one evaluation with your Physical Therapist combining innovative technology and clinical expertise to understand the underlying cause of your pain/movement dysfunction. The intent of the first visit is to create an individualized and specific road map for the Physical Therapist and patient to follow in order to achieve each patient's goals.

The therapist will discuss the following:

- Your medical history
- Your current problems/complaints
- Pain intensity, what aggravates and eases the problem
- How this is impacting your daily activities or your functional limitations
- Your goals with physical therapy
- Medications, tests, and procedures related to your health

The therapist will perform a variety of assessments to understand the symptoms you are experiencing and just as importantly, to devise a comprehensive program to treat the underlying cause of your problems. A plan is subsequently developed with the patient's input. This includes how many times you should see the therapist per week, how many weeks you will need therapy, home programs, patient education, short-term / long-term goals, and what is expected after discharge from therapy. This individualized plan is created with input from you, your therapist, and your doctor to help the patient achieve their goals as quickly as possible.

Please call us with any questions or concerns you may have.

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Whom may we thank for referring you?

❑ Doctor _____ ❑ Family Member _____
❑ Friend _____ ❑ Website _____ ❑ Other _____

Today's Date:

PATIENT INFORMATION

Last Name: First: Middle:

Home Phone Number:	Cell Phone Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	Zip Code:		
Email Address:				
Occupation:	Employer:	Employer Phone Number: ( )		

DOCTOR'S INFORMATION

Referring Physician/Family Doctor:

Phone Number:	

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Home Phone Number:	Cell or Work Phone Number:

The above information is true to the best of my knowledge. I consent to treatment for physical therapy. I authorize my insurance benefits to be paid directly to Atala Physical Therapy. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize Atala Physical Therapy to release any information required to process my claims and secure the payment of benefits

Patient/Guardian Signature *Date*

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PHYSICAL THERAPY EVALUATION

(To be completed by patient)

To help us assess the cause of your problem, we ask you to complete this form before being seen by a physical therapist. Please answer as completely as possible.

Your Full Name: _____

Referring Physician: _____

Current Height: _____ Current Weight : _____

Are you currently working? Yes ☐ No ☐. *If yes, please give your occupation and describe the physical demands of your job.* _____

_____

Have you fallen in the last six months? Yes ☐ No ☐. *If yes, please explain.* _____

_____

What physical activities/sports do you participate in on a regular basis? _____

_____

Complaint

What is your main complaint or problem (please be specific)? _____

_____

Are there any positions or activities that make your pain worse? Please List: _____

_____

Are there any positions or activities that lessen your pain? Please List: _____

_____

History *(Continue on back if needed)*

How did your problem start? _____

Please list prior surgeries and dates: _____

_____

Please list both previous and current diseases including, but not limited to, heart disease, lung disease, diabetes, stroke: _____

_____

Have you recently had an x-ray/MRI? When? Body Part? _____

_____

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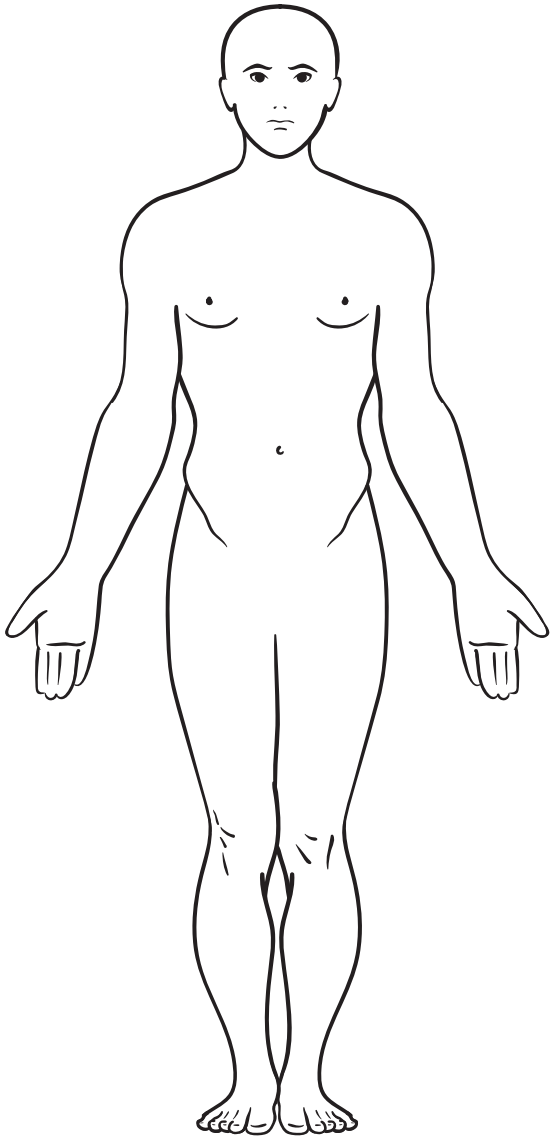
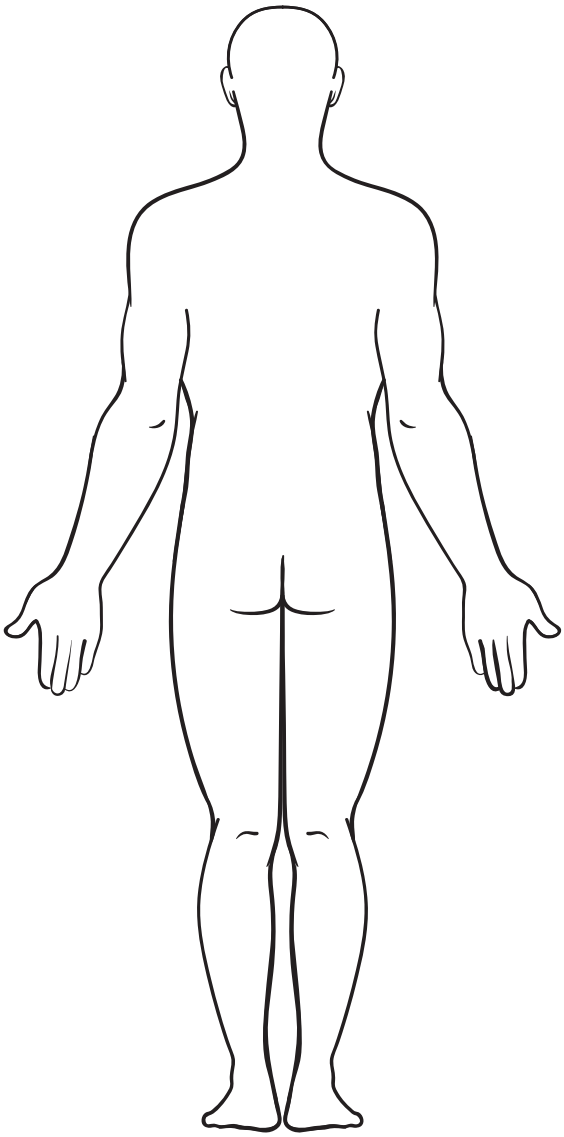
Areas of Concern

Indicate painful areas by shading these models.





Rate the intensity of pain.
Circle the appropriate number:

0=None 5=Moderate 10=Extreme

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

Which word best describes the quality of your discomfort?

Burning
Sharp
Dull/Achy
Shooting
Numbness / Tingling
Constant
Intermittent

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Medication History Worksheet

Due to insurance regulations, we must keep a record of any medications you are taking. Please take the time to fill out your medications, dosages and the reason for taking medications.

Medication	Dosage	Reason

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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.

Atala Physical Therapy's Legal Duty

Atala Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Atala Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives or other health related benefits that could be of interest to you.

Atala Physical Therapy may also use or disclose your health information, without prior authorization, for emergencies and auditing purposes. We also provide information when required by law. In any other situation, our 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.

Atala Physical Therapy 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 area and will be provided to you on your next visit. You may also 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 at any time. 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 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 in emergency circumstances. Atala Physical Therapy 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 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, please contact:

Terri Brusseau Kraus, Owner (760) 727-9100
Atala Physical Therapy, Grey Hawk Business Center, 3222 Grey Hawk Court, Carlsbad CA 92010

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

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

Atala Physical Therapy's Legal Duty

I have read and fully understand Atala Physical Therapy's Notice of Information Practices. I understand that Atala Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal information is used and disclosed for treatment, payment, and administrative operations, if I notify the practice. I also understand that Atala Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Atala Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Patient Name _____

Signature _____ Date _____

Signature of Guardian (if patient a minor) _____

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PAYMENT AUTHORIZATION FORM

Deductibles and Co-Pays

All patient responsibility deductibles and co-pays are due in full at the time of service. A receipt will be provided for any charges processed by Atala Physical Therapy, if requested. _____ **(initial)**

I have read the above and I agree to the terms and conditions. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Atala Physical Therapy. I agree to assign all health insurance benefits directly to Atala Physical Therapy and understand that I am responsible for any costs not covered by or denied by my health insurance.

Patient Signature _____ **Date** _____

**Our official corporate name is Atala Physical Therapy, Inc.
Thus, this official name may appear on your billing/credit card statement.**

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PATIENT TREATMENT AGREEMENT

_____ (initial) Cancellation Policy. I understand that if I cancel my scheduled appointment with less than 24 hours notice, or fail to show up for a scheduled appointment, a $50 cancellation fee will be assessed to me. I understand that if I fail to show up for a scheduled appointment without a call, a $75 no-show fee will be assessed to me.

_____ (initial) I understand that I need to verify my Physical Therapy Benefits directly with my health plan including, but not limited to, deductibles, co-pays, number of visits allowed, and prescription /pre-authorization required. I agree that I ultimately am financially responsible for the treatment provided to me in the event that my insurance carrier does not cover the full cost of my treatment. You will be provided a copy of your insurance verification form which details the benefits that Atala Physical Therapy confirmed for you on the date of your evaluation.

_____ (initial) I understand and agree that Atala Physical Therapy shall not be liable for the loss or theft of, or damage to, my personal property, including my vehicle and I hereby release in advance any such claims that I may have in further consideration of being treated at Atala Physical Therapy.

_____ (initial) I represent that I am physically able to safely participate in physical therapy and I have received clearance from my physician to undergo physical therapy.

_____ (initial) I understand and agree that I may be photographed or videotaped while receiving physical therapy for purposes of advertising and/or social media. However, in the event that I do not wish to be videotaped or photographed, I will notify Atala Physical Therapy.

I wish to OPT out of being photographed or videotaped:

Printed Name_____ Date _____

Signature _____

I agree that I have read, understand and agree to the terms listed above and that I have been advised to seek legal counsel in the event that I do not understand any of the above.

Printed Name_____ Date _____

Signature _____

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INFORMED CONSENT AGREEMENT

As a new patient of Atala Physical Therapy, I hereby acknowledge and understand the following:

Physical therapy means the art and science of physical or corrective rehabilitation or physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services (collectively "Therapy"). The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related to the health and wellness of individuals through the use of physical therapy interventions. Physical therapists are not authorized in California to diagnose disease(s).

Atala Physical Therapy does not discriminate and therapy being provided by Atala Physical Therapy is provided without regard to the patient's race, religion, gender, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. Response to therapy treatment varies by individual. Therefore, it cannot and Atala Physical Therapy has not, predicted my response to therapy. While the goal is for improvement of the condition in which I am seeking therapy, I understand that there is a possibility that my condition may worsen and therapy may cause pain, injury and even death. I also understand and acknowledge that I may develop new or different injuries as a result of my participation in a physical therapy program and in receiving therapy. With full knowledge of the above, I hereby knowingly and voluntarily assume any risks associated with the therapy that I receive and I, along with my heirs and assigns, fully and forever release Atala Physical Therapy, its owners, partners and providers of therapy services from any and all injury which may naturally occur and which are inherent in receiving therapy.

I understand that it is my right to decline to participate in physical therapy in general and specifically to any treatment proposed by Atala Physical Therapy and that I will immediately notify my physical therapist of any pain, discomfort, dizziness, or any other concern that I may have. I understand that it is my right to ask the physical therapist about my specific treatment plan along with the associated risks and benefits. I further acknowledge that I have consulted with my physician prior to participating in therapy to determine whether therapy is safe, warranted and recommended and I have been informed that it is.

I further acknowledge that I have been advised that I need to fully disclose any medical condition that I have that may affect my therapy and if I am not sure, I am advised to discuss such condition with my physical therapist prior to receiving therapy.

I have read, acknowledged, adopted, understood, and have agreed to be bound by the above.

Printed Name_____ Date _____

Signature _____

If under 18 years of age: PARENT or LEGAL GUARDIAN

Printed Name_____ Date _____

Signature _____