FELIX R. CANOUT REHABILITATION SERVICES, INC.

LAST NAME _____FIRST_____MIDDLE_____

SEX____ AGE____ DATE OF BIRTH _____SS#_____DRIVER'S LICENSE_____

ADDRESS (**No P.O. Box)**_____CITY _____STATE ____ZIP CODE _____

How may we contact you? Home □ _____ Work □ _____Cell □ _____

e-mail □ _____ other □ _____OCCUPATION_____

EMPLOYER _____PHONE # _____

EMPLOYER'S ADDRESS _____

CITY _____STATE _____ ZIP CODE _____

NAME OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU _____RELATIONSHIP_____

ADDRESS_____CITY _____STATE_____ZIP CODE_____

PHONE #:_____

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY? _____

PHONE # _____RELATIONSHIP _____

NAME OF DOCTOR RECOMMENDING THERAPY? _____PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

IS YOUR INJURY WORK RELATED? YES ___ NO ___ **If, Yes:** **Date of Injury** _____
Did you file a report? Yes ____ No____

CAR ACCIDENT RELATED? YES ___ NO ___ **If, Yes:** **Date of Injury** _____

SLIP AND FALL? YES ___ NO ___ **If, Yes:** **Date of Injury** _____

I HAVE COMPLETED THE ABOVE AND CERTIFY THAT IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU IMMEDIATELY OF ANY CHANGE IN THE ABOVE INFORMATION OR CHANGE IN MY HEALTH STATUS. I AUTHORIZE AND HEREBY GIVE MY CONSENT FOR TREATMENT AT THIS FACILITY.

I ALSO ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVATE PRACTICE AND I HAVE READ AND FULLY UNDERSTOOD (OR I WILL READ, IF I CHOOSE TO) THE FELIX R CANOUT REHABILITATION SERVICES, INC.'S NOTICE OF INFORMATION PRACTICES.

SIGNATURE _____**DATE** _____

Welcome to **Felix R Canout Rehabilitation Services, Inc.!**
Our Office hours are:
WCPT: M-T-W-TH-F 7:00 am – 6:00 pm
BHPT: M-W-F 7:00 am – 6:00 pm & T & TH 7:00 am – 12:00 pm

Proper **attire for therapy** would be comfortable clothing, such as shorts, sweats, T-shirts and tennis shoes. We kindly request that you do not bring small children into the gym area for safety reasons. The gym equipment is for patient use only.

If for any reason you can not make a scheduled appointment, please call our office at 213- 481-1515 (Wilshire Office) or 310-274-9307 (Beverly Hills Office). Our answering machine is on after hours and 24 hours Saturday and Sunday. **We do charge a fee of $40.00 for failing an appointment without giving our office at least 24 hours notice.** This charge is to cover our therapists' downtime, if we are unable to schedule someone else in that slot. (PLEASE NOTE: You are responsible for this $40.00 payment before or at your next visit. It is not covered by your insurance.) _____**INITIALS**

Payments for services are due at the time services are rendered. We accept cash, checks, credit cards; and assignment of insurance, once benefits are verified. **Insurance deductibles and any co-payment due will be collected at each visit**. **Returned checks and balances older than 90 days** may be subject to additional fees and interest charges of 1.5 % per month.

PLEASE REALIZE, HOWEVER, THAT:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.
2. Not all services are covered benefit in all contracts. We suggest you contact your insurance company, if you have any questions regarding coverage.
3. Acceptance of assignment of insurance benefits does not relieve you of your responsibility to pay deductibles, co-pays or non-covered services.
4. California law prohibits us from holding you financially responsible for payment of therapy services related to a work injury; this is the responsibility of your employer. Thus, if it is found your injury is work related, please notify us immediately.

We must emphasize that as therapy providers, our relationship is with you and not with your insurance company or other third party payer. While the filing of insurance claims is a courtesy we extend to you, all charges are due at the date services are rendered. Please, if problems arise, contact us for assistance in management of your account.

I hereby instruct and direct that my insurance company pays by check made out to:

FELIX R CANOUT REHABILITATION SERV ICES, INC.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above – mentioned assignee, and I have agreed to pay, in current manner, and balance of said professional service charges over and above this payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF MY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

I UNDERSTAND THE ABOVE AND I HAVE READ ALL THE INFORMATION ON THIS SHEET.

SIGNATURE_____DATE:_____

Body Chart

Last Name: _____ First Name: _____ Age: ___

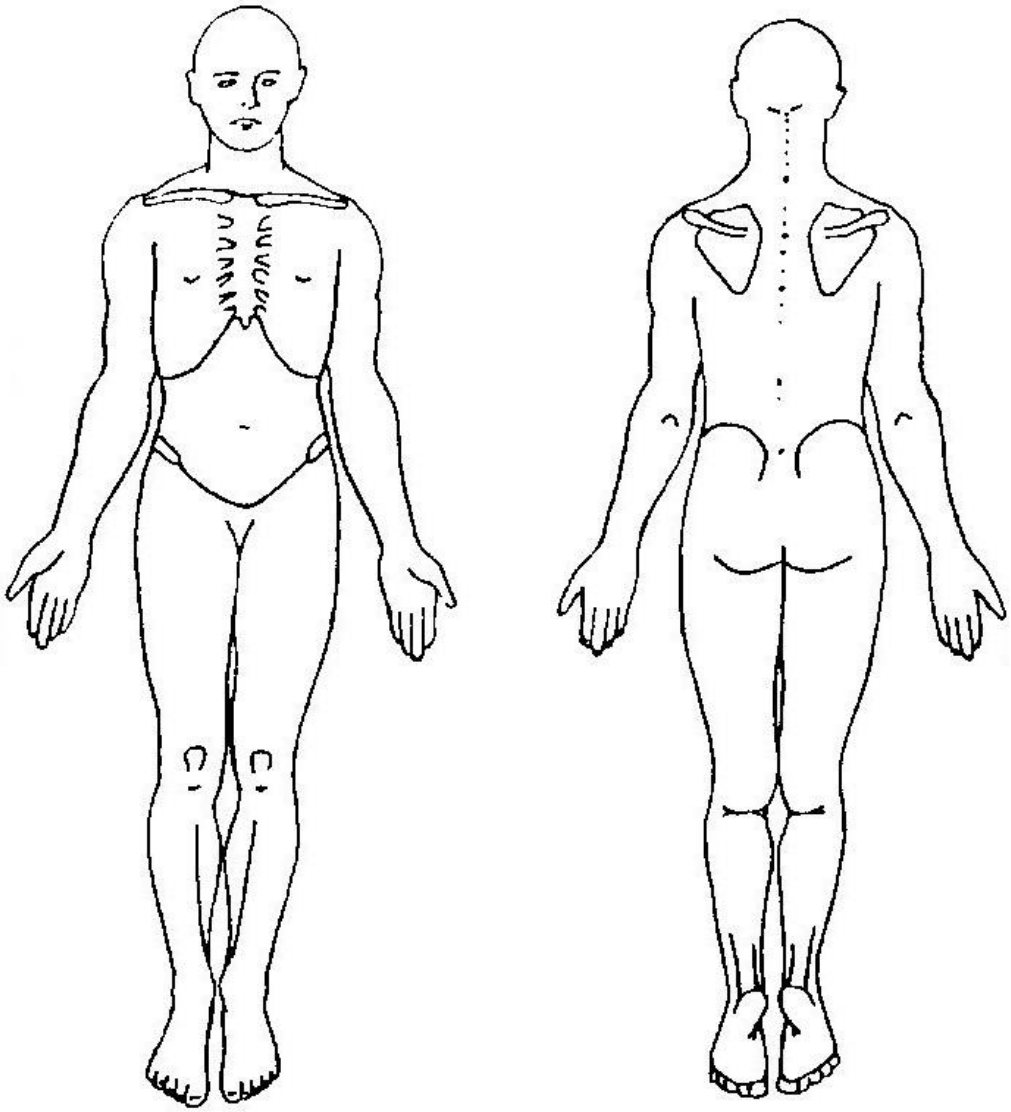
1. Please list any medications you are taking: _____

_____

_____

_____

2. Please indicate with an "X" the location of pain or discomfort on the diagram below.



Patient Signature: _____ Date: _____

FELIX R. CANOUT REHABILITATION SERVICES, INC.

Leading-edge treatment with a caring touch

CONSENT FORM

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability by evaluation, examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury or condition. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. **FELIX R. CANOUT REHABILITATION SERVICES, INC.** reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read and received a copy of the consent form and authorize release of medical information to appropriate third parties.

Patient's Signature_____ Date_____

FELIX R. CANOUT REHABILITATION SERVICES, INC.

NOTICE OF PATIENT INFORMATION PRACTICES – EFFECTIVE 04/14/2003

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.

FELIX R. CANOUT REHABILITATION SERVICES, INC.'s LEGAL DUTY

FELIX R. CANOUT REHABILITATION SERVICES, INC. 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

FELIX R. CANOUT REHABILITATION SERVICES, INC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, FELIX R. CANOUT REHABILITATION SERVICES, INC. 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.

FELIX R. CANOUT REHABILITATION SERVICES, INC. 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 required by law.

In any other situation, FELIX R. CANOUT REHABILITATION SERVICES, INC.'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.

FELIX R. CANOUT REHABILITATION SERVICES, INC. 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 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 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 in emergency circumstances. FELIX R. CANOUT REHABILITATION SERVICES, INC. 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 FELIX R. CANOUT REHABILITATION SERVICES, INC. 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 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 FELIX R. CANOUT REHABILITATION SERVICES, INC.'s health information practices or if you have a complaint, please contact the following person:

FELIX R. CANOUT REHABILITATION SERVICES, INC.
Wilshire Center Physical Therapy and Sports Rehabilitation
Beverly Hills Physical Therapy and Sports Rehabilitation Center
www.Canoutpt.com

FELIX R CANOUT REHABILITATION SERVICES, INC.

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand **FELIX R CANOUT REHABILITATION SERVICES, INC.'s** Notice of Information Practices. I understand that **FELIX R CANOUT REHABILITATION SERVICES, INC** 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 **FELIX R CANOUT REHABILITATION SERVICES, INC**. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in **FELIX R. CANOUT REHABILITATION SERVICES, INC.'s** Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize **FELIX R CANOUT REHABILITATION SERVICES, INC**. to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date