PATIENT REGISTRATION FORM

Date:_______________

Patient Information: (Please Print)

Patient's Name:____
First Middle Initial Last

Address:____
Street Address City State Zip

Home Phone: (______)______________________ Gender: ☐ M ☐ F Age:________ Date of Birth:______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Employer: (If Applicable) ______________________________________Occupation:______________________

Business Phone: (_______)____________________________ Cell Phone: (_______)___________________________

Employer's Address: ____
Street Address City State Zip

E-mail Address: ______________________________________ Add me to the 360 Balance Mailing List: ☐ Yes ☐ No

In case of emergency please contact: ____________________________Relation:__________________Phone: (_______) __________________

How did you hear about our clinic? ____

Insurance Information: ☐ SEE CARD(S)

Insurance Primary Cardholder: (If Person Other Than Yourself) __________________________________D.O.B.: __________________________

Social Security #: (If Primary Cardholder Is Person Other Than Yourself) ___________________________

Primary Cardholder Employer: (If Applicable) ____ Bus. Phone: ___________________

If Patient is a Minor:

Legal Guardian's Name::____
First Middle Initial Last

Address:____
Street Address City State Zip

Home Phone:______________________________ Business Phone:__________________________ Birthdate:______________________

Reason for Consultation:

Reason for Consultation: ____ Are you here regarding a work-related injury? ☐Yes ☐No

Referring Doctor: ___________________________________ Phone: _________________ Date of Last Visit with Referring Doctor: ______________

Family Physician: ____ Phone:______________________________________

Medicare Patients Only:

Have you received physical or occupational therapy from another provider during this calendar year? ☐ Yes ☐ No

Are you currently receiving any home health services (ex. PT, OT, Speech, Nursing, etc.)? ☐ Yes ☐ No

Thank you choosing us as your provider – your trust is very much appreciated.

HEALTH HISTORY QUESTIONNARE

All of the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Social/Health Habits:

Do you smoke tobacco? ☐ No ☐ Amount/day?___________
Do you drink alcohol? ☐ No ☐ Amount/week?__________
Do you recreational drugs? ☐ No ☐ Amount/week?__________
Do you exercise? ☐ No ☐ Yes
If yes, how many days per week? _____ minutes/day? ________
Describe exercise or activity: ____

Employment/Work:

Work Status: ☐ Unemployed ☐ Working Full-time ☐ Working light duty ☐ Student
☐ Homemaker ☐ Working Part-time ☐ Disabled ☐ Retired
Occupation:____

General Health Status:

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know
Major life Changes (past year): ☐ None ☐ Death in Family ☐ New Job ☐ Divorce ☐ Move

Family History:

Unknown

Please check if anyone in your family has or had any of the following:

☐ Heart disease ☐ High blood pressure ☐ Cancer ☐ Psychological problems
☐ Pulmonary/Lung disease ☐ Diabetes ☐ Arthritis ☐ Stroke
☐ Osteoporosis ☐ Allergies ☐ Hearing Loss ☐ Vertigo
☐ Balance problems ☐ Other:

Your Past Medical History:

☐ No history	☐ Diabetes	☐ Liver Disease	☐ Peripheral Neuropathy
☐ AIDS/HIV	☐ Emphysema	☐ Low blood pressure	☐ Prostate Disease
☐ Allergies	☐ Epilepsy/Seizures	☐ Lung disorder	☐ Skin disorder(s)
☐ Asthma	☐ Fibromyalgia	☐ Lupus	☐ Sleep disorder(s)
☐ Alzheimers/Dementia	☐ Glaucoma	☐ Lyme's Disease	☐ Stroke
☐ Anxiety/Depression	☐ Heart attack	☐ Macular Degeneration	☐ Thyroid disorders
☐ Arthritis	☐ Heart Disease	☐ Meniere's Disease	☐ Ulcers (stomach)
☐ Blood disorders	☐ Hepatitis	☐ Migraines	☐ Repeated infections
☐ Broken bones	☐ Head Injury	☐ Muscular Dystrophy	☐ Vertigo
☐ Chronic Fatigue Syndrome	☐ High blood pressure	☐ Multiple Sclerosis	☐ ________________
☐ Circulation problems	☐ High cholesterol	☐ Osteoporosis	☐ ________________
☐ Cancer________________	☐ Genetic Disease	☐ Pacemaker	☐ ________________
☐ Crohn's Disease	☐ Kidney Disease	☐ Parkinson's Disease	☐ ________________

For women only:

Pelvic Inflammatory Disease? ☐ No ☐ Yes
Complicated pregnancies? ☐ No ☐ Yes
Endometriosis? ☐ No ☐ Yes
Increase in current symptoms with hormonal changes? ☐ No ☐ Yes

Trouble with period? ☐ No ☐ Yes
Currently pregnant? ☐ No ☐ Yes
Other:

Surgical History: SEE ATTACHED:

Please list any surgeries you have had and, if known, include dates:

☐ No surgeries to date

1.______________________________ Date:_________ 2.______________________________ Date:_________

3.______________________________ Date:_________ 4.______________________________ Date:_________

Symptom Checklist:

Within the last year, have you had any of the following (check all that apply):

☐ No symptoms
☐ Bowel problems
☐ Chest pain
☐ Cough (persistent)
☐ Concentration problems
☐ Difficulty driving
☐ Difficulty walking
☐ Difficulty sleeping
☐ Dizziness
☐ Excessive sweating
☐ Fatigue
☐ Foggy headedness
☐ Headaches
☐ Hearing loss
☐ Heart palpitations
☐ Joint pain or swelling
☐ Loss of appetite
☐ Loss of balance
☐ Motion sickness
☐ Nausea/Vomiting
☐ Numbness in arms/legs
☐ Pain at night
☐ Pressure in your ears
☐ Shortness of breath
☐ Syncope (passing out)
☐ Tinnitus (noises in your ear)
☐ Tremors
☐ Urinary problems
☐ Vertigo
☐ Vision problems
☐ Weakness in arms/legs
☐ Weight gain (unexplained)
☐ Weight loss (unexplained)
☐ Dizziness with loud noises
☐ Dizziness with physical exertion
☐ Other:_______________________

Diagnostic Tests / Measures:

Within the last year, have you had any of the following (check all that apply):

☐ No diagnostic testing
☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Blood test
☐ Bone scan
☐ Other:
☐ Bronchoscopy
☐ CT scan
☐ Ultrasound
☐ Echocardiogram
☐ EEG
☐ EKG
☐ Hearing tests
☐ Mammogram
☐ MRI
☐ Pap smear
☐ EMG/Nerve conduction
☐ ENG
☐ Pulmonary Function Test
☐ Speech/Language evaluation
☐ Stool test
☐ Stress test
☐ Urine test
☐ X-Ray

Medications:

Please check or list all medications or allergies:

Non-Prescription:

☐ No medications
☐ Advil/Alleve
☐ Antihistamine
☐ Aspirin
☐ Decongestants
☐ Excedrin
☐ Herbal supplements
☐ Ibuprofen/Naproxen
☐ Motrin
☐ Vitamins/minerals
☐ Tylenol
☐ Other:

Prescription:

☐ No medications
☐ ________________________________ ☐ ________________________________ ☐ ________________________________
☐ See attached list

Allergies:

☐ Drug allergies: ☐ No ☐ Yes, please list:____
☐ Airborne pathogens: ☐ No ☐ Yes, please list:____

Are you receiving any treatment for above stated allergies? If yes, please describe:

____

☐ **Check here, if you are not experiencing any dizziness or unsteadiness and can leave form blank.**

Dizziness Handicap Inventory-Screening version (DHI-S)

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please place a check in the appropriate column for "**y**es," "**n**o," or "**s**ometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

	Y (4)	**N (0)**	**S (2)**
E1. Because of your symptoms, do you feel depressed?	___	___	___
P2. Does walking increase your symptoms?	___	___	___
E3. Because of your symptoms, is it difficult to concentrate?	___	___	___
F4. Because of your symptoms, is it difficult for you to walk around your house in the dark?	___	___	___
P5. Does bending over increase your symptoms?	___	___	___
F6. Because of your symptoms, do you restrict your travel for business or recreation?	___	___	___
F7. Do your symptoms interfere with your job or household responsibilities?	___	___	___
E8. Because of your symptoms, are you afraid to leave your home without having someone with you?	___	___	___
E9. Because of your symptoms, have you ever been embarrassed in front of others?	___	___	___
F10. Do your symptoms significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?	___	___	___

Total Score: ______

Please Review and Sign Below

Consent of Treatment, Authorization to Release Information, Billing Disclosures/Financial Responsibility and No Show Policy:

Patient Name: ____

I hereby authorize 360 Balance & Dizziness through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition. Such services may be offered onsite or online via telerehabilitation/e-health services.I further authorize 360 Balance & Dizziness to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided. I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

At 360 Balance & Dizziness, our mission is to value every individual and meet the healthcare needs of patients and their families that suffer from dizziness, balance and/or hearing disorders. The service you have elected to participate in implies a financial responsibility on your part. You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier whether services are rendered in-person or online. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If collection for this invoice is placed in the hands of an attorney, attorney fees equal to 30% of the total invoice price shall be due and owing. If any legal action is required, it is agreed that the venue for such shall be in Travis County, Texas.

I have read the above information regarding my financial responsibility to 360 Balance & Dizziness for providing services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to 360 Balance & Hearing. I agree to pay 360 Balance & Dizziness the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

I hereby authorize 360 Balance & Dizziness to furnish information to insurance carriers and doctors concerning my illness and treatments, by fax or mail.

I hereby authorize 360 Balance & Dizziness to disclose my health information that is directly related to my current treatment at 360 Balance & Dizziness to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/ girlfriends, domestic partners, neighbors and colleagues.

Name: ___________________________________ Relationship: _____________________________________

There is a $50 no-show/late-cancellation fee for physical therapy appointments and a $75 no-show/late-cancellation fee for audiology appointments. All appointments must be canceled by 5 p.m. of the previous day (or by 2 p.m. on Friday for a Monday appointment), to avoid charges for a no-show or late-cancellation. After-hour messages regarding cancellations may be left at 512-345-4664. Insurance will not cover charges for no-show/late-cancellation or eligibility fees. I acknowledge that I have read and understand the No Show Policy.

Note: Please check ONE of the following options.

By signing below, I consent to both onsite (in-person) and online (telerehabilitation) services.
Be signing below, I consent to onsite (in-person) services only.
Be signing below, I consent to online (telerehabilitation) services only.

Signature: ____________________________________(relationship to patient: self - guardian - other: _____________)

Date: ______________

Health Insurance
Portability & Accountability Act

360 BALANCE & DIZZINESS

The Health Insurance Portability and Accountability Act (HIPAA) provide rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances. HIPAA may also give you a right to purchase individual coverage if you have no group health plan coverage available, and have exhausted COBRA or other continuation coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date
- Under HIPAA, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSAs Web site at www.dol.gov/ebsa/.
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence - like pay stubs, explanation of benefits, letters from a doctor - if you cannot get a certificate

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors

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www.360balance.com
Compliance Officer: Bridgett Wallace

By signing below, I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature ______________________ Date __________