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: _____

360 Balance & Dizziness Center
T: 512-345-4664
www.360balance.com

Patient Name: _____ Date of Birth (MM/DD/YEAR): _____

1. I agree that my healthcare provider and I wish to engage in a telerehabilitation consultation.
2. I understand that the video conferencing technology used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telerehabilitation consult/E-visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I agree that the email address I provided to 360 Balance & Dizziness is mine and no other individual has access to my email account. This email address matches the email address where I received this consent form.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telerehabilitation examination room: and or (3) terminate the consultation at any time.
6. I understand that sessions may be recorded for medical documentation purposes, and that I can opt out of this recording at any time, including before and during any E-visit.
7. I have had the alternatives to a telerehabilitation consultation explained to me. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
8. In an emergent consultation, I understand that the responsibility of the telerehabilitation consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
9. I have had the opportunity to ask questions regarding this service delivery method. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this document, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the service delivery method.
- That I have been given ample opportunity to ask questions and that any questions that have been answered to my satisfaction.

_____
Date

_____
Patient's/Parent/Guardian Signature

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.coom
Compliance Officer: Bridgett Wallace

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

Signature _____ Date _____