COMBATATHLETES
PHYSICALTHERAPY

Dear First Time Patient,

Welcome to the "Combat Athletes Physical Therapy," and thank you very much for your interest and appointment with us!

Enclosed you will find the necessary paperwork that should be filled out at the first visit and before your evaluation with your physical therapist. Please take this opportunity to complete the paperwork to the best of your ability, review each document, and sign it.
Here are other things that we would like to get your attention.

For your appointment, please bring:

- Comfortable clothes such as gym attire
- A pair of most commonly worn shoes (for assessment)
- Payment (cash, check, credit/debit card. Please see Payment Policy for the details)
- Additional information such as X-ray, MRI, and other comparable reports if available
- An open mind to learn something new about yourself.

We look forward to seeing you and helping you achieve your goals!
Respectfully,

Combat Athletes Physical Therapy

"We are...
- Physical Therapist | Movement Expert | Orthopedic Specialist | Strength & Conditioning Specialist - who Alleviate Pain, Enhance Function, Prevent Injury, and Improve Performance."

Physical Therapy Intake Form

COMBATATHLETES
PHYSICALTHERAPY

*Please fill out the information below completely and clearly before your PT evaluation.

Patient Information

Last name: ______________________ First Name: ______________________

Height: ________ Weight: ________ Gender: ☐M/☐F Age: ___ Marital Status: ☐Single ☐Married ☐Other

Address: ______________________ City: ______________ Zip: ______

Referring Type: Self / Physician / Others ______________________ DOB: ____/____/_____

Cell Phone: ______________ Home Phone: ______________ Email: ______________

Occupation: ______________________ Currently Working ☐Y ☐N Employer: ______________

Person to contact in case of emergency:

Name: ______________________ Phone: ______________ Relationship: ______________

How did you hear about our office: ______________________

Injury/Condition Information

What problem or diagnosis brings your in today? ______________________

____

Date of injury: ____/____/________

Type of injury/Condition: ☐Auto Accident ☐Work Related ☐Sports ☐Other: ______________

What treatment/tests have you already received for this condition? (i.g. x-ray, MRI, surgery, massage, etc)

____

Please explain how your condition happened: ______________________

____

Please rate your pain on a scale from 0 (no pain) to 10 (worst pain, requiring ambulance):

CURRENT amount of pain since injury: 0 1 2 3 4 5 6 7 8 9 10

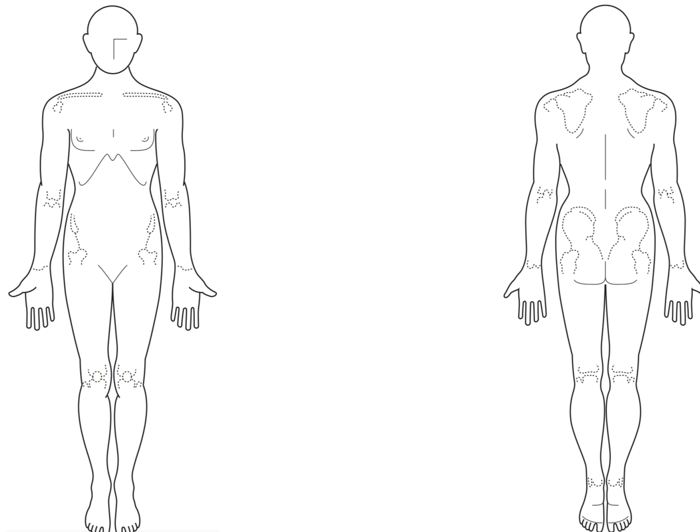
LEAST amount of pain since injury: 0 1 2 3 4 5 6 7 8 9 10

MOST amount of pain since injury: 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms BETTER?: ______________________

What makes your symptoms WORSE?: ______________________

Please use the diagram below to mark where your current symptoms are:



Medical History

Please circle all that apply:

Allergies
Anemia
Anxiety
Arthritis
Asthma
Autoimmune Disorder
Cancer
Cardiac Conditions
Cardiac Pacemaker
Chemical Dependency
Circulation Problems
COVID-19
Currently Pregnant
Depression

Diabetes
Dizzy Spells
Emphysema/Bronchitis
Fibromyalgia
Fractures
Gallbladder Problems
Headaches
Hearing Impairment
Hepatitis
High Cholesterol
High/Low Blood Pressure
HIV/AIDS
Incontinence
Kidney Problems

Metal Implants
MRSA
Multiple Sclerosis
Muscular Disease
Osteoporosis
Parkinson
Rheumatoid Arthritis
Seizures
Smoking
Speech Problems
Strokes
Thyroid Disease
Tuberculosis
Vision Problems

Other: ___________________
____
____

Current Medications

Drug: ________________ Dosage:________ Frequency:_________ Reason for taking__________________________
Drug: ________________ Dosage:________ Frequency:_________ Reason for taking__________________________
Drug: ________________ Dosage:________ Frequency:_________ Reason for taking__________________________
Drug: ________________ Dosage:________ Frequency:_________ Reason for taking__________________________

Previous Surgeries

Surgery: ____ Date:__________________________
Surgery: ____ Date:__________________________
Surgery: ____ Date:__________________________
Surgery: ____ Date:__________________________

Patient Authorization

I hereby authorize my consent as a patient for physical therapy evaluation and treatments rendered by Combat Athletes Physical Therapy. I understand 24-hours notification cancellations policy and no refund policy on all services and products provided at Combat Athletes Physical Therapy. A 50% of the fee for a missed visit will be incurred if there are consistent lapses in scheduled attendance. I give Combat Athletes Physical Therapy my consent to perform physical therapy services according to the recommended plan of treatment provided by my therapist. I give my permission to leave a message on my voice mail regarding physical therapy and emergency situations. I hereby certify that all of the information provided by me in this application (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge.

Patient's Signature: ____ Date: _________________

Patient's Printed Name: ____

_ _

**Consent to Treat a Minor (*Fill out only if patient is under the age of 18*):*

I / We being the parent / legal guardian of a minor age of do hereby consent, authorize, and request Combat Athletes Physical Therapy to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I / we agree to hold Combat Athletes Physical Therapy free and harmless from any claims, suits, damages or complications which may result from such treatment.

Signature of Parent/Legal guardian: ____ Date: _________________

Payment Policy

Payment for services can be made by cash, check, or credit/debit card with the following details.

Payment Options

- Check should be made out to Combat Athletes Physical Therapy.
- Combat Athletes Physical Therapy has a NO REFUND policy on all provided services.
- Services offered may be canceled at any time at the discretion of Dr. Ilseong Song, PT, DPT.
- Any advanced payment for services not rendered will be refunded in full or partially refunded according the term set forth below, unless the pre-paid consultation or package has expired according the terms of purchase below.
- Any bounced check is subject to the full amount of the check, plus fees up to $80.
- Once a receipt of payment for services has been issued, whether issued electronically or in hard copy, any request for duplicate copy of receipt is subject to inconvenience fees of up to $50.
- Terms of payment, fee schedules and cancellation policy, agreed upon by a signed initial consent form with Dr. Ilseong Song, PT, DPT for private vestibular trainings, clinical consulting and business development, supersede the general payment policy as outlined above on this page.

Refund Policy

- We have a no refund policy on all services and products provided by Dr. Ilseong Song, PT, DPT. This includes, but it not limited to, service package fee, monthly membership fees, upgrade fees, professional services fees, regardless of usage.
- In the unlikely event that you are not satisfied with your purchase, Combat Athletes Physical Therapy will work with you on a reasonable solution.
- If your account is canceled by the company for violation of this agreement, policy, or patient intake form, all payments made to Combat Athletes Physical Therapy become completely nonrefundable.
- All visit packages must be used within one year of purchase. If unused, pre-paid follow up physical therapy visits will expire at the end of the month one year from the date of purchase. No refund can be processed in this case.
- Client agrees not to charge back any credit card payments for services rendered. In the event that a customer files a charge back or other payment dispute, they will be considered to be in violation of this agreement and may be subject to collection action. There may be a fee charged to the client by Combat Athletes Physical Therapy for cost of fees associated with a charge back.

Practice Policy

- Any services including Physical Therapy, Recovery, Strength & Conditioning, Musculoskeletal Ultrasound Imaging, etc provided by Dr. Ilseong Song, PT, DPT are not covered by any types of health insurance.
- Some patients choose to purchase a package of five, seven or ten follow up physical therapy visits after the initial physical therapy evaluation and treatment completed.
- All visit packages must be used within one year of purchase. If unused, pre-paid follow up physical therapy visits will expire at the end of the month one year from the date of purchase.
- For returning patients who have not been seen in person for the last 6 months, or have a change in medical status like a hospital stay or surgery, a Physical Therapy In-Person Re-Evaluation is required to initiate a New Episode of Care.
- In-person visits may need to be rescheduled if the clinician is sick or if the patient has a cold, cough, fever or flu on the scheduled date of in-person consultation as those conditions may interfere with the results of the evaluation.

Membership Policy

- Your membership with Combat Athletes Physical Therapy will automatically be renewed at the end of the membership term unless: (1) you request to turn off the auto-renew feature prior to the expiration date of your then existing membership; or (2) you request a cancellation within thirty (30) days from the date your renewal payment has been accepted and processed (in which case you will receive a full refund of the renewal payment). NO REFUND will be given, in whole or in part, if you request a cancellation more than thirty (30) days after your renewal payment has been accepted and processed or if you have utilized services within the current renewal period. Your access to the membership-based features will continue only for the remainder of the renewed membership term.
- To cancel your membership renewal, please contact us through the “Contact Us” page, email, or by phone call.
- Client can upgrade or downgrade level of our memberships at any time of your usage, however Combat Athletes Physical Therapy does not refund any fees in that case or prorate within the 30 days of the membership fee. If you stop using our services in between the term, we will not refund you the fees paid by you for the remaining term. We reserve the right to modify or terminate the Combat Athletes Physical Therapy for any reason, without notice at any time.

By way of my signature, it indicates that I have read this Payment Policy section and understand my rights and obligation regarding this payment policy section.

Patients Signature: Patient’s Name (print): Date:

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Combat Athletes Physical Therapy, its affiliates and its employees. Combat Athletes Physical Therapy will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Combat Athletes Physical Therapy. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;

- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.
Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Combat Athlete Physical Therapy in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Combat Athletes Physical Therapy office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights Department of HHS
200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Combat Athletes Physical Therapy by phone at (858) 284-1133 or at the following address: 7340 MIRAMAR RD, STE. 210, SAN DIEGO, CA 92126.
I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Combat Athletes Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patients Signature: Patient’s Name (print): Date: