

Dear Patient,

Included in this packet are all the forms you will need to bring with you to your first appointment.

Please bring a prescription from your doctor requesting physical therapy, your insurance cards and a photo ID with you to your appointment.

The clinic is open each morning at 9am. Please be aware that the clinic is closed before 9 am each day and between 11:00 am and 12:30 pm on M, W and F. If your appointment is the first appointment in the morning or after lunch, please be aware that the clinic doors will be locked before 9am and during lunch.

Please be advised, that if for any reason you need to cancel your appointment we require a 24 hour notice. *A \$50 fee will be charged for any **no shows**, and a \$25 fee for any **cancellations that occur without 24 hours notice and any cancellations that occur after 3 cancellations.** All no show and cancelation fees are the **direct responsibility of the patient.** Insurance will not pay these fees.*

Please fill out all sections included in your packet **completely** prior to your visit to ensure that the therapist is provided enough time to complete your evaluation. Your evaluation will be completed over the course of 2 visits, each one hour in length.

***Please wear pants or shorts and shoes with non-slip soles. Your shoes should have heels no higher than a tennis shoe. Tennis shoes or similar are the best option if you have them available***

For driving directions to the clinic, please go to [www.equilibrium-bpc.com](http://www.equilibrium-bpc.com). Click on the "Location" page and enter your address in the Google maps link.

I look forward to meeting you.

Sincerely,

Amy M. Griffin, M.S., P.T.  
Vestibular and Balance Rehabilitation Specialist  
EQUILIBRIUM Balance Performance Center  
Physical Therapy

2387 Portola Rd., Suite B  
Ventura, CA 93003  
Ofc. 805-339-9718  
Fax 805-339-9728  
e-mail: [vertigoinfo@equilibrium-bpc.com](mailto:vertigoinfo@equilibrium-bpc.com)

## **CANCELATION POLICY**

Dear Patient,

Our office requests if an appointment needs to be cancelled, that we receive notice **no later than 24 hours** prior to the appointment.

There is no charge for cancellations made with notice provided 24 hours in advance.

There is also no charge for your first 3 late **CANCELLATIONS** made without the requested 24 hour notice.

Beginning with the 4th late **CANCELLATION**, and each there after, a **\$25.00 fee** will be assessed.

**NO SHOW** appointments, including your initial evaluation visit, will be assessed a **\$50.00** fee.

Late **CANCELLATIONS** for **INITIAL EVALUATIONS** will also be assessed a **\$50.00** fee.

**CANCELLATIONS** and **NO SHOW** fees are the patient's responsibility. Insurance will not pay these fees. Fees are due on or before your next appointment.

- If you reschedule your INITIAL EVALUATION and arrive as scheduled, \$25 of your late "**CANCELLATION**" fee may be waived. "**NO SHOWS**" will still be ASSESSED a \$50.00 fee. If you are not scheduled for another visit a bill will be mailed to you, due payable upon receipt.

Please understand that we value the time of ALL our patients. No show and late cancelled visits tie up the therapist's availability to provide needed services to dedicated patients.

Thank you,

EQUILIBRIUM Balance Performance Center  
Physical Therapy and Pilates



## Patient Consent/Acknowledgement Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to revise our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosure we have already made based on your prior Consent.

**Equilibrium Balance Performance Center, PT, Inc.** provides this form to comply with the Health Insurance Portability and Accountability Act (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- **Equilibrium Balance Performance Center, PT, Inc.** has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- **Equilibrium Balance Performance Center, PT, Inc.** reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information **but Equilibrium Balance Performance Center, PT, Inc.** does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosure will then cease.
- **Equilibrium Balance Performance Center, PT, Inc.** may condition the treatment upon the execution of this Consent.

Name: (*please print*): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A copy of the "Notice of Privacy Practices" will be given to me at my request.



\*PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ - \_\_\_\_\_

\*NEUROLOGIST: \_\_\_\_\_

\*EAR NOSE & THROAT (ENT): \_\_\_\_\_

\*CARDIOLOGIST: \_\_\_\_\_

PLEASE CHECK TO ALLOW EPBC, PT TO SEND A COPY OF YOUR EVALUATION TO YOUR DOCTORS LISTED ABOVE

**QUESTIONNAIRE**

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**DIAGNOSIS:** (reason you are here): \_\_\_\_\_

Are you currently being seen by any of the following?

- Physical Therapist
- Speech Therapist
- Occupational Therapist
- Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason: \_\_\_\_\_

Have you had therapy for this recent illness?  Yes  No

If you answered yes, please explain where and when, and the outcome of the therapy: \_\_\_\_\_

INITIAL ONSET DATE OF SYMPTOMS/EXACERBATION: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PRIMARY SYMPTOMS: \_\_\_\_\_

WHAT CAUSED YOUR SYMPTOM ONSET/EXACERBATION: \_\_\_\_\_

MEDICAL HISTORY RELATED TO YOUR CURRENT SYMPTOMS: \_\_\_\_\_

SEVERITY OF PAIN: (rated 0-10) \_\_\_\_ / 10

WHAT AGGRAVATES YOUR SYMPTOMS: \_\_\_\_\_

ACTIVITIES RESTRICTED DUE TO CONDITION: \_\_\_\_\_

**OTHER MEDICAL HISTORY:** Have you had or do you suffer from: (Check all that apply)

- Heart problems \_\_\_\_\_
- Diabetes
- Stroke/Neurological
- Multiple Sclerosis
- Parkinson's Disease
- Seizures/Convulsions
- Kidney disease
- Cancer
- Life threatening infection

- Cardiac/heart disease  
 Fibromyalgia  
 Rheumatoid Arthritis  
 Depression  
 Do you drink alcohol?  Yes  No how much? \_\_\_\_\_ Use tobacco?  Yes  No packs/day \_\_\_\_\_  
 Use recreational drugs? Have a dependency on prescription drugs?  Yes  No how much? \_\_\_\_\_  
 Recent flu/Virus (please specify): \_\_\_\_\_

**Orthopedic conditions / surgeries – (please list)** \_\_\_\_\_

### MEDICATIONS

Please List: \_\_\_\_\_

### PREVIOUS LEVEL OF FUNCTION

Describe: \_\_\_\_\_

### CURRENT LEVEL OF FUNCTION

Describe: \_\_\_\_\_

#### RELEASE OF MEDICAL INFORMATION \_\_\_\_\_ initials

I authorize EQUILIBRIUM Balance Performance Center, PT, Inc to release medical records concerning my self / son / daughter / other dependent to any physician, hospital, or agency involved in the care of the patient listed.

#### ASSIGNMENT OF MEDICAL BENEFITS \_\_\_\_\_ initials

I authorize my insurance carrier to assign medical benefits to EQUILIBRIUM Balance Performance Center, PT, Inc. I also authorize release of medical information necessary to process all medical insurance claims.

#### PAYMENT POLICY \_\_\_\_\_ initials

Co-payments are due at the time services are received. We accept cash and check only at this time. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility / non-payable / non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

#### CANCELATION POLICY \_\_\_\_\_ initials

Our office requests that if an appointment needs to be cancelled, that we receive notice **no later than 24 hours notice** prior to the appointment. **I, the patient, agree to pay a \$50.00 fee** for each **cancellation** following the third and beginning with the fourth, as well as **any cancellation later than the requested 24 hour notice**. **In addition I, the patient, agree to pay the automatic \$50.00 fee** for any “no show” appointments. The cancellation and no show fees are to be collected on or before your next appointment.

#### REFERRAL POLICY \_\_\_\_\_ initials

I understand it is my responsibility to obtain a prescription from my referring physician’s office to receive therapy services. Failure to do so will result in charges being billed in full directly to myself. In addition, all therapy services will be placed on hold until the physician’s prescription for therapy services is received.

**I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES AND CLINIC POLICIES:**

X \_\_\_\_\_  
**SIGNATURE OF RESPONSIBLE PARTY**

X \_\_\_\_\_  
**DATE READ AND SIGNED**