AUM Physical Therapy & Yoga Center
Dhaval Buch, P.T.

1002 Calloway Drive, Bakersfield, CA 93312
(661) LUV4-AUM 588-4286 • Fax 588-9986

PATIENT INFORMATION

	Last	First	Middle Initial	Marital Status	Sex	Age	Date of Birth	Social Security Number
Name								

Address _____
Number and Street City State Zip Phone

Insurance Coverage? Yes ☐ No ☐ E-Mail Address: _____ Cell Phone: _____

Name of Employer _____

Employer's Address _____
Number and Street City State Zip Phone

Occupation _____ How Long Employed? _____

If Not Employed, Source of Income: _____

Spouse's Name _____

Occupation _____ Date of Birth: _____ Social Security # _____

Employer's Name and Address _____
Number and Street City State/Zip Phone

If Student; Name of School _____

Nearest Relative / Friend (Not living in the home) _____
Name Relationship Phone

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____
Name of Insurance Name of Insurance

AUTO ACCIDENT / PERSONAL INJURY INFORMATION

☐ **On the Job** ☐ **Traffic Accident** ☐ **At School** ☐ **At Home** ☐ **Other**_____

Insured Name: _____ Insurance Carrier: _____
Claim Number: _____ Insurance Address: _____
Adjuster _____ _____
Date of Injury: _____ Telephone: _____
Do you have an attorney for this case? **Yes** ☐ **No** ☐
Attorney Name: _____ Attorney Phone: _____

AUTHORIZATION FOR MEDICAL TREATMENT / ASSIGNMENT OF BENEFITS / MEDICAL LIEN

Authorization for Medical Treatment: I hereby authorize AUM Physical Therapy & Yoga Center, Inc. to administer and order any treatment and perform such procedures as may be deemed necessary and advisable in the treatment of the above named patient.

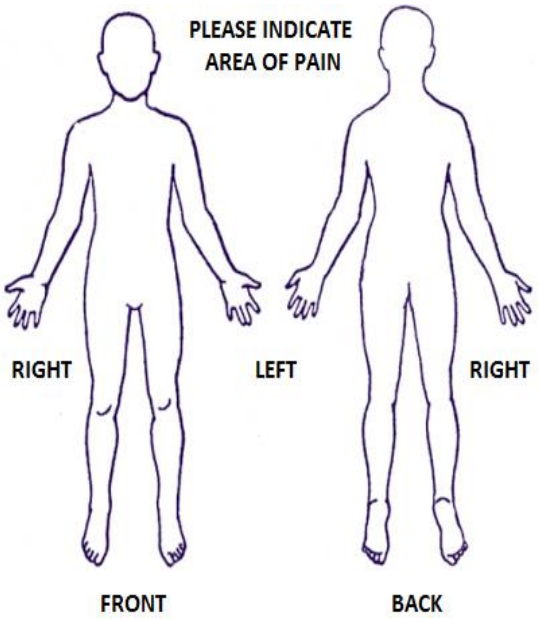
Assignment of Benefits: I hereby assign all Physical Therapy benefits, to include major medical benefits to which I am entitled to AUM Physical Therapy & Yoga Center, Inc. (APTYC). I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical/automobile med pay plan, or my attorney to issue payment check(s) directly to APTYC for Physical Therapy services rendered to me and/or my dependents regardless of my insurance benefits, if any. **I understand that I am fully responsible for: (i) knowing my insurance benefits for Physical Therapy, (ii) all co-payments, deductible balances and any charges not covered by insurance at the time of service.** All information gathered by APTYC is a courtesy. In the event the insurance company issues payment to me, for services rendered, I agree not to cash any insurance checks and will endorse the payment to APTYC, to represent payment for treatment I have received.

Medical Lien: I hereby direct my attorney, if applicable, to pay directly to APTYC any sums as may be due for Physical Therapy services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate APTYC. I hereby further give a lien on my case to said practice against any and all proceeds of my settlement, judgment, or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection therewith.

X _____ _____
Patient/ Legal Guardian Signature **Date**

PLEASE PROVIDE YOUR MEDICAL HISTORY BELOW:

DIABETES	YES	NO	ARE YOU PREGNANT?	YES	NO
HIGH BLOOD PRESSURE . .	YES	NO	ALLERGIES	YES	NO
STROKE	YES	NO	SINUS ALLERGY	YES	NO
HEART ATTACK	YES	NO	PREVIOUS SURGERY.	YES	NO
HEART SURGERY	YES	NO	JOINT REPLACEMENT	YES	NO
PACEMAKER	YES	NO	METAL IMPLANTS.	YES	NO
HEADACHES	YES	NO	CANCER	YES	NO
MIGRAINES	YES	NO	ARTHRITIS	YES	NO
NERVOUSNESS	YES	NO	RHEUMATOID ARTHRITIS. . .	YES	NO
ANXIETY	YES	NO	GOUT	YES	NO
DEPRESSION	YES	NO	OSTEOPOROSIS	YES	NO
SEIZURES	YES	NO	SENSITIVE HEAT / ICE.	YES	NO
FIBROMYALGIA	YES	NO	SLEEPING PROBLEMS.	YES	NO
LUPUS	YES	NO	TMJ / JAW PAIN.	YES	NO
ASTHMA	YES	NO	SINUS PROBLEMS	YES	NO
COPD	YES	NO	NEUROPATHY	YES	NO
HERNIA	YES	NO	PSYCHIATRIC CARE	YES	NO
VISION PROBLEMS	YES	NO	VARICOSE VEINS	YES	NO
VERTIGO	YES	NO	KIDNEY PROBLEMS	YES	NO
CONSTIPATION	YES	NO	AUTO ACCIDENTS	YES	NO
ULCERS	YES	NO	HYSTERECTOMY	YES	NO



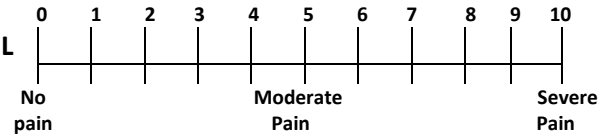
If YES to any of the above, please explain and give approximate dates: _____

_____

_____

_____

PLEASE RATE YOUR PAIN LEVEL



Are you currently taking any medication? Yes ☐ No ☐ If YES, please list all medications and for what condition:

_____

_____

_____

Have you had Physical Therapy/ Occupational Therapy/ Speech Therapy / Chiropractic /Home Health services for this or any other condition within the last 12 months?

Yes ☐ No ☐ If YES, please provide details of when (approx. dates), where and total number of visits

_____

_____

Notice of Privacy Practices:

I certify that I have received information about the Notice of Privacy Practices from AUM Physical Therapy & Yoga Center, Inc. regarding the HIPAA rules which became effective April 13, 2003.

The above information is correct to the best of my knowledge.

X _____ _____

Patient/Legal Guardian Signature **Date**

MEDICAL HISTORY FORM

PATIENT NAME: _____ Date: _____

For how long have you had this pain? _____

Was there any injury (recent or old) which may have caused the pain?_____

_____

Do you feel dizziness or any loss of balance? _____

Have you had any falls – recently or in the past 12 months? _____

Have you had any car accidents – recently or in the past? _____

Have you had any fractures? _____

Have you had any neck/ back/ joint surgeries? _____

What activities make the pain worse? _____

_____

What helps in reducing the pain? _____

What are the activities that you are limited &/or unable to perform due to the pain? _____

_____

What activities would you like to be able to do most? _____

Have you had any injections or surgery for this pain? _____

_____

Have you had any cosmetic surgery? (if yes, indicate which areas) _____

_____

Have you had any Physical Therapy, Acupuncture or Chiropractic for this pain? (If yes, please specify approximately how many visits, how long ago & if it helped) _____

_____

Do you do any type of exercises/workouts on your own or in a gym on a regular basis with/without a trainer? _____

Do you have shortness of breath with even a small amount of activity?_____

Do you get recurring infections – lungs, urinary tract? _____

Do you get tired easily?_____

Do you wake up feeling refreshed every morning? _____

How much water do you drink everyday (excluding tea, coffee, juices)? _____

Do you have a bowel movement daily? _____ If not, what is the average frequency? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY LIFE ACTIVITIES. PLEASE CIRCLE IN EACH SECTION THE *ONE NUMBER* THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE CIRCLE THE NUMBER THAT *MOST CLOSELY* DESCRIBES YOUR PRESENT-DAY SITUATION.

SECTION 1 - PAIN INTENSITY

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself, and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

0. I can lift heavy weights without causing extra pain.
1. I can lift heavy weights, but it gives me extra pain.
2. Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

SECTION 4 – WORK

0. I can do as much work as I want.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I can't do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

SECTION 5 – HEADACHES

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time.

SECTION 6 – CONCENTRATION

0. I can concentrate fully without difficulty.
1. I can concentrate fully with slight difficulty.
2. I have a fair degree of difficulty concentrating.
3. I have a lot of difficulty concentrating.
4. I have a great deal of difficulty concentrating.
5. I can't concentrate at all.

SECTION 7 – SLEEPING

0. I have no trouble sleeping.
1. My sleep is slightly disturbed for less than 1 hour.
2. My sleep is mildly disturbed for up to 1-2 hours.
3. My sleep is moderately disturbed for up to 2-3 hours.
4. My sleep is greatly disturbed for up to 3-5 hours.
5. My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

0. I can drive my car without neck pain.
1. I can drive as long as I want with slight neck pain.
2. I can drive as long as I want with moderate neck pain.
3. I can't drive as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I can't drive my car at all because of neck pain.

SECTION 9 – READING

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much I want with moderate neck pain.
3. I can't read as much as I want because of moderate neck pain
4. I can't read as much I want because of severe neck pain.
5. I can't read at all.

SECTION 10 – RECREATION

0. I have no neck pain during all recreational activities.
1. I have some neck pain with a few recreational activities.
2. I have neck pain with most recreational activities.
3. I have neck pain with all recreational activities.
4. I can hardly do recreational activities due to neck pain.
5. I can't do any recreational activities due to neck pain.

PATIENT NAME _____ **DATE** _____

SCORE _____[50] **BENCHMARK** -5 = _____

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

NAME: _____

DATE: _____

WE ARE INTERESTED IN KNOWING WHETHER YOU ARE HAVING ANY DIFFICULTY WITH THE ACTIVITIES LISTED BELOW BECAUSE OF YOUR UPPER LIMB PROBLEM FOR WHICH YOU ARE CURRENTLY SEEKING ATTENTION. **PLEASE PROVIDE AN ANSWER FOR EACH ACTIVITY**.

TODAY, *DO YOU* OR *WOULD YOU* HAVE ANY DIFFICULTY AT ALL WITH:

ACTIVITIES	EXTREME DIFFICULTY OR UNABLE TO PERFORM ACTIVITY	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY
1. ANY OF YOUR USUAL WORK, HOUSEWORK, OR SCHOOL ACTIVITIES	0	1	2	3	4
2. YOUR USUAL HOBBIES, RECREATIONAL OR SPORTS ACTIVITIES	0	1	2	3	4
3. LIFTING A BAG OF GROCERIES TO WAIST LEVEL	0	1	2	3	4
4. LIFTING A BAG OF GROCERIES ABOVE YOUR HEAD	0	1	2	3	4
5. GROOMING YOUR HAIR	0	1	2	3	4
6. PUSHING UP ON YOUR HANDS (e.g. FROM BATHTUB OR CHAIR)	0	1	2	3	4
7. PREPARING FOOD (e.g. PEELING, CUTTING)	0	1	2	3	4
8. DRIVING	0	1	2	3	4
9. VACUUMING, SWEEPING OR RAKING	0	1	2	3	4
10. DRESSING	0	1	2	3	4
11. DOING UP BUTTONS	0	1	2	3	4
12. USING TOOLS OR APPLIANCES	0	1	2	3	4
13. OPENING DOORS	0	1	2	3	4
14. CLEANING	0	1	2	3	4
15. TYING OR LACING SHOES	0	1	2	3	4
16. SLEEPING	0	1	2	3	4
17. LAUNDERING CLOTHES (e.g. WASHING, IRONING, FOLDING)	0	1	2	3	4
18. OPENING A JAR	0	1	2	3	4
19. THROWING A BALL	0	1	2	3	4
20. CARRYING A SMALL SUITCASE WITH YOUR AFFECTED LIMB	0	1	2	3	4
COLUMN TOTALS:					

MINIMUM LEVEL OF DETECTABLE CHANGE (90% CONFIDENCE): 9 POINTS SCORE:_____/80

Source: Stratford et al (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada 53 (4): 259-67. Minimum detectable change (90% confidence): 6 points

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PATIENT NAME:

DATE:

INSTRUCTIONS:

THIS QUESTIONNAIRE HAS BEEN DESIGNED TO GIVE US INFORMATION AS TO HOW YOUR BACK OR LEG PAIN IS AFFECTING YOUR ABILITY TO MANAGE IN EVERYDAY LIFE. PLEASE ANSWER BY CIRCLING ONE NUMBER IN EACH SECTION FOR THE STATEMENT WHICH BEST APPLIES TO YOU. WE REALIZE YOU MAY CONSIDER THAT TWO OR MORE STATEMENTS IN ANY ONE SECTION MAY APPLY, BUT PLEASE CHOOSE ONE NUMBER THAT INDICATES THE STATEMENT WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM TODAY.

SECTION 1 - PAIN INTENSITY

0. I HAVE NO PAIN AT THE MOMENT
1. THE PAIN IS VERY MILD AT THE MOMENT
2. THE PAIN IS MODERATE AT THE MOMENT
3. THE PAIN IS FAIRLY SEVERE AT THE MOMENT
4. THE PAIN IS VERY SEVERE AT THE MOMENT
5. THE PAIN IS THE WORST IMAGINABLE AT THE MOMENT

SECTION 2 - PERSONAL CARE (WASHING, DRESSING, ETC.)

0. I CAN LOOK AFTER MYSELF NORMALLY WITHOUT CAUSING EXTRA PAIN
1. I CAN LOOK AFTER MYSELF NORMALLY BUT IT CAUSES EXTRA PAIN
2. IT IS PAINFUL TO LOOK AFTER MYSELF AND I AM SLOW AND CAREFUL
3. I NEED SOME HELP BUT MANAGE MOST OF MY PERSONAL CARE
4. I NEED HELP EVERY DAY IN MOST ASPECTS OF SELF CARE
5. I DO NOT GET DRESSED, I WASH WITH DIFFICULTY AND STAY IN BED

SECTION 3 - LIFTING

0. I CAN LIFT HEAVY WEIGHTS WITHOUT EXTRA PAIN
1. I CAN LIFT HEAVY WEIGHTS BUT IT GIVES EXTRA PAIN
2. PAIN PREVENTS ME FROM LIFTING HEAVY WEIGHTS OFF THE FLOOR BUT I CAN MANAGE IF THEY ARE CONVENIENTLY POSITIONED
3. PAIN PREVENTS ME FROM LIFTING HEAVY WEIGHTS, BUT I CAN MANAGE LIGHT TO MEDIUM WEIGHTS IF THEY ARE CONVENIENTLY POSITIONED.
4. I CAN LIFT VERY LIGHT WEIGHT
5. I CANNOT LIFT OR CARRY ANYTHING AT ALL

SECTION 4 - WALKING

0. PAIN DOES NOT PREVENT ME WALKING ANY DISTANCE
1. PAIN PREVENTS ME FROM WALKING MORE THAN1 MILE
2. PAIN PREVENTS ME FROM WALKING MORE THAN ½ MILE.
3. PAIN PREVENTS ME FROM WALKING MORE THAN 500 YARDS
4. I CAN ONLY WALK USING A STICK OR CRUTCHES
5. I AM IN BED MOST OF THE TIME

SECTION 5 - SITTING

0. I CAN SIT IN ANY CHAIR AS LONG AS I LIKE
1. I CAN ONLY SIT IN MY FAVORITE CHAIR AS LONG AS I LIKE
2. PAIN PREVENTS ME FROM SITTING MORE THAN ONE HOUR
3. PAIN PREVENTS ME FROM SITTING MORE THAN 30 MINUTES
4. PAIN PREVENTS ME FROM SITTING MORE THAN 10 MINUTES
5. PAIN PREVENTS ME FROM SITTING AT ALL

SECTION 6 - STANDING

0. I CAN STAND AS LONG AS I WANT WITHOUT EXTRA PAIN
1. I CAN STAND AS LONG AS I WANT BUT IT GIVES ME EXTRA PAIN
2. PAIN PREVENTS ME FROM STANDING FOR MORE THAN 1 HOUR
3. PAIN PREVENTS ME FROM STANDING FOR MORE THAN 10 MINUTES
4. PAIN PREVENTS ME FROM STANDING FOR MORE THAN 3 MINUTES
5. PAIN PREVENTS ME FROM STANDING AT ALL

SECTION 7- SLEEPING

0. MY SLEEP IS NEVER DISTURBED BY PAIN
1. MY SLEEP IS OCCASIONALLY DISTURBED BY PAIN
2. BECAUSE OF MY PAIN I HAVE LESS THAN 6 HOURS OF SLEEP
3. BECAUSE OF MY PAIN I HAVE LESS THAN 4 HOURS OF SLEEP
4. BECAUSE OF MY PAIN I HAVE LESS THAN 2 HOURS OF SLEEP
5. PAIN PREVENTS ME FROM SLEEPING AT ALL

SECTION 8 - SEX LIFE (IF APPLICABLE)

0. MY SEX LIFE IS NORMAL AND CAUSES NO EXTRA PAIN
1. MY SEX LIFE IS NORMAL BUT CAUSES SOME EXTRA PAIN
2. MY SEX LIFE IS NEARLY NORMAL BUT IS VERY PAINFUL
3. MY SEX LIFE IS SEVERELY RESTRICTED BY PAIN
4. MY SEX LIFE IS NEARLY ABSENT BECAUSE OF PAIN
5. PAIN PREVENTS ANY SEX LIFE AT ALL

SECTION 9 - SOCIAL LIFE

0. MY SOCIAL LIFE IS NORMAL AND GIVES ME NO EXTRA PAIN
1. MY SOCIAL LIFE IS NORMAL BUT INCREASES THE DEGREE OF PAIN
2. PAIN HAS NO SIGNIFICANT EFFECT ON MY SOCIAL LIFE APART FROM LIMITING MY MORE ENERGETIC INTERESTS E.G. SPORTS
3. PAIN HAS RESTRICTED MY SOCIAL LIFE, I DON'T GO OUT AS OFTEN
4. PAIN HAS RESTRICTED MY SOCIAL LIFE TO MY HOME
5. I HAVE NO SOCIAL LIFE BECAUSE OF PAIN

SECTION 10 - TRAVELING

0. I CAN TRAVEL ANYWHERE WITHOUT PAIN
1. I CAN TRAVEL ANYWHERE BUT IT GIVES ME EXTRA PAIN
2. PAIN IS BAD BUT I MANAGE JOURNEYS OVER TWO HOURS
3. PAIN RESTRICTS ME TO JOURNEYS OF LESS THAN ONE HOUR
4. PAIN RESTRICTS ME TO SHORT NECESSARY JOURNEYS UNDER 30 MINUTES.
5. PAIN PREVENTS ME FROM TRAVELLING EXCEPT TO RECEIVE TREATMENT.

TOTAL:_____

LOWER EXTREMITY FUNCTIONAL SCALE (LEFS) **NAME: _____**

DATE: _____

INSTRUCTIONS

WE ARE INTERESTED IN KNOWING WHETHER YOU ARE HAVING ANY DIFFICULTY WITH THE ACTIVITIES LISTED BELOW BECAUSE OF YOUR LOWER LIMB PROBLEM FOR WHICH YOU ARE CURRENTLY SEEKING ATTENTION. **PLEASE PROVIDE AN ANSWER FOR EACH ACTIVITY**.

TODAY, *DO YOU* OR *WOULD YOU* HAVE ANY DIFFICULTY AT ALL WITH:

ACTIVITIES	EXTREME DIFFICULTY OR UNABLE TO PERFORM ACTIVITY	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY
1. ANY OF YOUR USUAL WORK, HOUSEWORK, OR SCHOOL ACTIVITIES.	0	1	2	3	4
2. YOUR USUAL HOBBIES, RECREATIONAL OR SPORTS ACTIVITIES.	0	1	2	3	4
3. GETTING INTO OR OUT OF THE BATH.	0	1	2	3	4
4. WALKING BETWEEN ROOMS.	0	1	2	3	4
5. PUTTING ON YOUR SHOES OR SOCKS.	0	1	2	3	4
6. SQUATTING.	0	1	2	3	4
7. LIFTING AN OBJECT, LIKE A BAG OF GROCERIES FROM THE FLOOR.	0	1	2	3	4
8. PERFORMING LIGHT ACTIVITIES AROUND YOUR HOME.	0	1	2	3	4
9. PERFORMING HEAVY ACTIVITIES AROUND YOUR HOME.	0	1	2	3	4
10. GETTING INTO OR OUT OF A CAR.	0	1	2	3	4
11. WALKING 2 BLOCKS	0	1	2	3	4
12. WALKING A MILE.	0	1	2	3	4
13. GOING UP OR DOWN 10 STAIRS (ABOUT 1 FLIGHT OF STAIRS.)	0	1	2	3	4
14. STANDING FOR 1 HOUR.	0	1	2	3	4
15. SITTING FOR 1 HOUR.	0	1	2	3	4
16. RUNNING ON EVEN GROUND.	0	1	2	3	4
17. RUNNING ON UNEVEN GROUND.	0	1	2	3	4
18. MAKING SHARP TURNS WHILE RUNNING FAST.	0	1	2	3	4
19. HOPPING.	0	1	2	3	4
20. ROLLING OVER IN BED.	0	1	2	3	4
COLUMN TOTALS:					

Jaw Functional Limitation Scale – 8

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

		No limitation										**Severe Limitation**
1.	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2.	Chew chicken (e.g., prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
3.	Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
4.	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
5.	Swallow	0	1	2	3	4	5	6	7	8	9	10
6.	Yawn	0	1	2	3	4	5	6	7	8	9	10
7.	Talk	0	1	2	3	4	5	6	7	8	9	10
8.	Smile	0	1	2	3	4	5	6	7	8	9	10

AUM Center 1002 Calloway Drive Bakersfield, California 93312 (661) 588-4286 Fax (661) 588-9986

Assignment of Benefits – Financial Lien

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. Insurance billing is provided only as a courtesy.

Assignment of Benefits

I hereby assign all Physical Therapy benefits, to include major medical benefits to which I am entitled to AUM Physical Therapy & Yoga Center (herein referred to as AUM Center). **I understand it is my responsibility to understand my insurance coverage for Physical Therapy & ensure my benefits are in effect from month to month and to notify AUM Center of any benefit changes or changes in insurance coverage**. I understand it is my responsibility to notify AUM Center about any Home Health services I may be receiving for my health condition, as outpatient Physical Therapy is not a covered benefit at the same time as Home Health services. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to include auto insurance, to issue payment check(s) directly to AUM Center for Physical Therapy Services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I further agree in the event my medical insurance, auto insurance or attorney, inadvertently forwards payment to me for treatment received, I will endorse said payment to AUM Center for services rendered. I also agree to reimburse AUM Center in the event my insurance carrier requests a refund of service fees from AUM Center for any reason.

I hereby direct my attorney, if applicable, to pay directly to AUM Center any sums as may be due for Physical Therapy services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate AUM Center. And, I hereby further give a lien on my case to said practice against any and all proceeds of my settlement, judgment, or verdict which may be paid to my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

Authorization to Release Information

I hereby authorize AUM Center to: (1) release any information necessary to insurance carriers regarding my illness and/or treatment; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested Physical Therapy services from AUM Center on behalf of myself and or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

Patient/Responsible Party **FULL NAME**	Date
Patient/Responsible Party **SIGNATURE**	Date

AUM
PHYSICAL THERAPY & YOGA CENTER
HOLISTIC PAIN & STRESS RELIEF

Dhaval Buch, PT
FIBROMYALGIA * CHRONIC PAIN * HEADACHES * TMJ * STRESS/ANXIETY ETC... * YOGA * REIKI, PRANIC HEALING

Appointment Cancellation Policy

Dear Patient,

We are committed to providing you the best Physical Therapy service you can receive to help you with your condition. In return, we expect that you participate in your recovery by keeping your appointments as prescribed by your physician/insurance & following through with the home program that we give you.

The appointment time that we give you is reserved exclusively for you.

If you do not make it for your scheduled appointment, it deprives another patient, like yourself - who may also want an appointment at the same time. In addition, it also leads to down time for our staff, increasing overhead costs.

Please give us at least 24 hours notice for any cancelled appointments i.e. previous working day.

If you fail to notify us, then we have no choice but charge you a $25.00 Cancellation/No-Show fee.

No exceptions! Please note that your insurance company will not pay this fee.

We appreciate your co-operation & understanding.

Thank You,

AUM Physical Therapy & Yoga Center

I understand and hereby agree to comply with the appointment cancellation policy.

PATIENT/GUARDIAN NAME **SIGNATURE** **DATE**

AUM Physical Therapy and Yoga Center, Inc.
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Official. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information Based Upon Your Written Consent You will be asked by us to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, we will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use your protected health information for other marketing activities. For example, your name and address (postal or e-mail) may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you. We may use or disclose your demographic information and the data that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physical therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to the person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you. Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use of disclosure under the circumstances. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization. These situation include: Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (5) medical emergency (not on the Practice's premises) and it is likely that a crime as occurred. Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for organ, eye or tissue donation purposes. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of the foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President of others legally authorized. Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care for you. Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section165.500 et.seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. *You have the right to inspect and copy your protected health information.* This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record. *You have the right to request a restriction of your protected health information*. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physical therapist is not required to agree to a restriction that you may request. If the physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physical therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish with your physical therapist. You may request a restriction by completing and filing a Request for Limitations and Restrictions of Protected Health Information form in your medical record. *You have the right to request to receive confidential communications from us by alternative means or at an alternative location.* We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer. *You may have the right to have your physical therapist amend your protected health information.* This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record. *You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.* This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us.

3. Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, at (661) 588-4286 for further information about the complaint process.

This notice was published and becomes effective on 04-01-2003. Office Manager 05-2010