Nuvè
Therapeutics

3525 N. Verdugo Rd
Glendale, CA 91208
818-272-1563

Nuvè Therapeutics **NEW CLIENT INTAKE**

Name: _____ Date: _____

Address: _____ City:_____ State :_____ Zip:_____
Home (__)_____ Cell(__)_____Work(__)_____
Do you prefer (circle): call or text What line circle: Home Cell Work
Email Address: _____
Birth date:_____ Age: _____ Occupation: _____
Single: _____ Married:_____ Spouse's Name _____
Contact in case of Emergency: _____
Have you had Physical Therapy before? Yes No If yes, When: _____
Primary Care Physician, Location & Contact #_____
OFFICE USE ICD 10_____
Whom may we thank for referring you:_____ Contact Information:_____

HEALTH SUMMARY

How and When did your problems begin? Location of injury?
_____
Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Circle:
Pain description: ♦ Dull ♦ Ache ♦ Sharp ♦ Stabbing ♦ Pins & Needles ♦Shooting Pain ♦ Burning ♦ Throbbing ♦ Twinge ♦ Numbness/Tingling ♦ Other_____
Does your pain wake you up at night? ♦ Yes ♦ No
Are you ever totally pain free? ♦ Yes ♦ No
List any medication you are taking:_____
Have you had any root canals? ♦ Yes ♦ No
Are you Pregnant? ♦ Yes ♦ No
Have you had diagnostic studies for your current condition? (X-ray, MRI, CT scan...)
♦ Yes ♦ No When:_____
Any other orthopedic problems? ♦ Yes ♦ No
If yes, please explain:_____
_____
Any medical problems? ♦ Yes ♦ No
If yes, please explain:_____
_____
Any surgeries? ♦ Yes ♦ No
If yes, please explain _____
Have you ever had a history of any of the following? Check all that applies even if they don't seem related to your current condition
♦ Cancer/tumors ♦ Osteoporosis ♦ Dizziness/Blackouts/Vertigo ♦ Heart problems/angina ♦ Diabetes ♦ Pacemaker ♦ Sudden weight loss/gain ♦ Severe pain at night ♦ Smoking ♦ Bruising easily ♦ Asthma ♦ Frequent falls ♦ Loss of bowel/bladder control ♦ Numbness in hands or toes ♦Pins and Needles in legs ♦ Seizures/epilepsy ♦ High blood pressure ♦ Coordination loss ♦Constipation ♦Neck Stiff ♦Back pain ♦ Ringing in ears ♦Allergies

The statements made on this are accurate to the best of my recollection and allow this office to exam me for further evaluation
Patient Signature: _____
Parent/Guardian Signature: _____

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Appointment Cancellation Policy

Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While awareness and sensitivity to the fact that an emergency may occur, cancellations, especially last minute ones, along with patient no-shows, decrease the ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. Full cooperation with the following policy is appreciated:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be canceled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment. Please call/text at (818) 272-1563 with your notification.
- Failure to show up for an appointment ("NO SHOW") without notifying the therapist will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. The therapist will do everything possible to accommodate you, as space on the schedule permits.
- Late cancellations due to illness or family emergencies are excluded from this policy.
- The No-Show Appointment Fee is as follows:
    - $65 CANCELLATION FEE for late-canceled or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR

As a courtesy, we will send you a confirmation text to remind you of your scheduled appointment. Keep in mind this is a courtesy action. Upon scheduling your appointment time you are committed to your appointment and our cancellation policy/fee.

I understand the appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify the therapist appropriately if I have difficulty fulfilling my scheduled appointments.

Patient /Guardian Signature Date

_____

Witness Signature Date_____

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CONSENT TO PHYSICAL THERAPY SCREEN AND TREATMENT

I hereby consent to screen and/or treatment of my condition by a licensed physical therapist

1. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence.
2. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.
3. The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.

I have been given on opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Patient's Name _____ Signature_____
Date _____

- The Patient refused to sign this form.
- The Patient would not sign the form because the patient said he/she did not understand the Notice.
- Other (explain in detail)

_____
_____
_____

Witness Signature, Date: _____

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Yvonne Ramirez, DPT
3525 N Verdugo Rd. Glendale, CA 91208 818-473-9457

HIPPA Security Rule

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information.[1] To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" must put in place to secure individuals' "electronic protected health information" (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.

1. Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit
2. Identify and protect against reasonably anticipated threats to the security or integrity of the information
3. Protect against reasonably anticipated, impermissible uses or disclosures; and
4. Ensure compliance by their workforce

The Security Rule defines "confidentiality" to mean that e-PHI is not available or disclosed to unauthorized persons. The Security Rule's confidentiality requirements support the Privacy Rule's prohibitions against improper uses and disclosures of PHI. The Security rule also promotes the two additional goals of maintaining the integrity and availability of e-PHI. Under the Security Rule, "integrity" means that e-PHI is not altered or destroyed in an unauthorized manner. "Availability" means that e-PHI is accessible and usable on demand by an authorized person.

Patient Guardian Signature/Date_____
Patient Signature/Date _____