WELCOME TO ILYA KAMINSKY D.C., RPT, INC.

Today's Date: _____/_____/_____ Date of Injury: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____
Last First MI

Social Security #: _____-_____-_____ Marital Status: _____ D/L #: _____

Sex: M ___ F ___ Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone : (_____) _____

Home Address: _____
Street Apt. #

_____
City State Zip Code

Employer: _____ Occupation: _____

Business Address: _____
Street Suite

_____
City State Zip Code

Referred By: _____

Physician: _____ Phone #: _____

Spouse Name: _____ Wk Phone #: _____

Emergency Contact: _____ Phone #: _____

Insurance Information
Please Present Insurance ID Card and Claim forms to the Receptionist

Insured Party: _____ Self: _____ Spouse: _____ Parent: _____ Other: _____

Name (If other than self): _____
Last First MI

S.S.#: _____-_____-_____ Date of Birth of Insured: _____/_____/_____

Insurance Company Name: _____ Phone: _____

Authorization to Pay Medical Fees & Financial Agreement

I hereby authorize the medical provider in charge of my case to furnish my insurance company with information concerning my treatment. A photocopy of this authorization will be considered as valid as the original. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

ILYA KAMINSKY, D.C., R.P.T., INC.
16260 Ventura Blvd., #705, Encino, CA 91436

The medical expense benefits allowable and otherwise payable to me under my current insurance policy, including major medical benefits, as payment toward the total charge for professional service rendered. This payment will not exceed my indebtedness to above mentioned assignee and I agree to pay in a current manner any balance of said professional service charges over and above this insurance payment. If legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee, and/or collection fee. In the event the insurance proceeds are not applicable or insufficient, I agree to pay the indebtedness individually.

Signature of Patient: _____ Date: _____/_____/_____

CONSENT TO PHYSICAL THERAPY AND CHIROPRACTIC SERVICES

1. I, _____, authorize Dr. Ilya Kaminsky and his staff to perform on me the following procedure(s):

   a) Massage + soft tissue mobilization + myofascial techniques
   b) Mobilization Techniques
   c) Manipulations
   d) Interferential Treatment
   e) Therapeutic exercise program

2. In addition, I consent to the performance of any other diagnostic and therapeutic procedures the reason for which may or may not be dependent on presently known conditions, but its purpose appropriate and remain to my case management.

3. The nature and purpose of the procedures, possible alternatives, the potential risks, consequences, and the possibility of complications have been explained to my satisfaction.

4. I acknowledge that no guarantee has been made nor has any assurance of results been given me by any provider of clinical service in this office regarding the procedures I've consented to.

Date_____ Patient's Signature_____

MR#_____ _____ (printed name)

Witness_____ Relationship_____

Ilya Kaminsky, D.C., R.P.T., a Professional Corporation
6333 Wilshire Blvd., Suite 101, Los Angeles, CA 90048 Phone (323) 966-2676 Fax (323) 966-2677
16260 Ventura Blvd., Suite 705, Encino, CA 91436 Phone (818) 995-7500 Fax (818) 995-7957

ILYA KAMINSKY, D.C., R.P.T.,
A PROFESSIONAL CORPORATION

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Full payment is due at time of service.
We accept cash, check, or credit cards.
We offer an extended payment plan with prior credit approval.

Regarding insurance:

In order for us to bill your insurance company, we require that you provide us with your insurance information, and if necessary, an original claim form. Your insurance policy is a contract between you and insurance company. We are not a part of that contract. In the event that we do accept assignment of benefits from your insurance company, we require that you pay any and all unpaid balances. We can offer you a pre-approved payment plan, or you may provide us with a credit card with authorization to bill that account for the balance.

If your insurance company has not paid your account in full in 60 days, the balance will automatically become yours. Please be advised that some, and perhaps all, of the services provided may be non-covered services, and not considered reasonable and customary under the Medicare program and or other medical insurance. If you have any questions regarding reasonable and customary charges for your insurance policy, please contact to them directly.

All co-payments and deductibles are due prior to treatment.

YOUR CO-PAYMENT EACH VISIT WILL BE $_____.

Usual and Customary Rates:

Our office is committed to providing the best treatment for our patients, and we charge what is reasonable and customary for our area. You are responsible for payment of all medical services rendered by our office.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge a $ 40.00 fee for missed appointment. Based on your request for scheduling, we make our staff available for your needs. Please help us to serve you better by keeping scheduled appointments.

Please let us know if you have any questions or comments.

I understand and agree to the above Financial Policy.

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Patient's Signature Date

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Signature of Policy Holder Date

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ILYA KAMINSKY, D.C., R.P.T.

Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your information. The law also requires us to give you this notice about our practices, our legal duties, and your right concerning your health information. We must follow he privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms are effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and the new notice will be available upon request.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use your health information for treatment or disclose it to a registered physical therapist, physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another healthcare provider or entity that is subject to the Federal Privacy Rule for its payment activities.
Healthcare Operations: We may use and disclose your healthcare information for our healthcare operations, including quality assessment, and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. We may also disclose your health information to another healthcare provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their healthcare operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.
On your authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect nay uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reasons except those described in this notice.
To your family and friends: We may disclose your health information to a family member or friend or other necessary to help you with y our healthcare or with payment for your healthcare. Before we disclose your health information to those people we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event that you are incapable, or in the event of in emergency, we will disclose your medical information based on our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up a filled prescription, medical supplies, X-ray or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care of your location and general conditions.
Appointment reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post card, or letter).

X_____ _____

Signature Date

Ilya Kaminsky, D.C., R.P.T., a Professional Corporation
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