



Ian A Novotny PT, DPT

Ian A Novotny, PT, DPT received his Bachelor of Arts in Biology from Whittier College in Whittier, California and his Doctorate in Physical Therapy from Drexel University in Philadelphia, Pennsylvania. His research on health policy and cost for the treatment of low back dysfunction has been presented nationally and received recognition as the most outstanding platform presentation for the Health Policy Section of the American Physical Therapy Association's annual conference in 2004.

He has participated in National Institutes of Health research grant projects for Shoulder Dysfunction in Patients with Spinal Cord Injuries Who Use a Manual Wheelchair at Magee Rehabilitation Hospital and Rancho Los Amigos National Rehabilitation Center. Ian has taught advanced practitioner certification courses in physical agents and modalities. He has practiced in numerous settings including outpatient orthopedics, inpatient spinal cord injury, acute care, pathokinology research, and is the current co-owner of BACK 2 HEALTH PHYSICAL THERAPY.



Vladislav Shut PT, DPT, MS, ATC, CSCS

Vladislav Shut, PT, DPT, MS, ATC, CSCS received his Bachelor of Science in Athletic Training/ Sports Medicine from Westchester University in Westchester, Pennsylvania, his Master of Science in Athletic Training/ Sports Medicine from California University of Pennsylvania in Pittsburgh, Pennsylvania and his Doctorate in Physical Therapy from Drexel University in Philadelphia, Pennsylvania. He was the director of Strength Training Incorporated (STI), an outpatient orthopedic physical therapy clinic in Scottsdale, AZ.

Vladislav has worked with professional athletes for the Arizona Rattlers (Arena Football), Arizona Diamondbacks, and Arizona Cardinals as well as the elderly in home health, military personnel in the United States Coast Guard, and children with orthopedic and neurological conditions. Through his clinical residencies, didactic studies, and experience in orthopedics, sports medicine, strength and conditioning, neurology, acute care, and manual therapy he has developed his style of eclectic physical therapy. He is the current co-owner of BACK 2 HEALTH PHYSICAL THERAPY.



Physical Therapy & Aquatic Rehabilitation

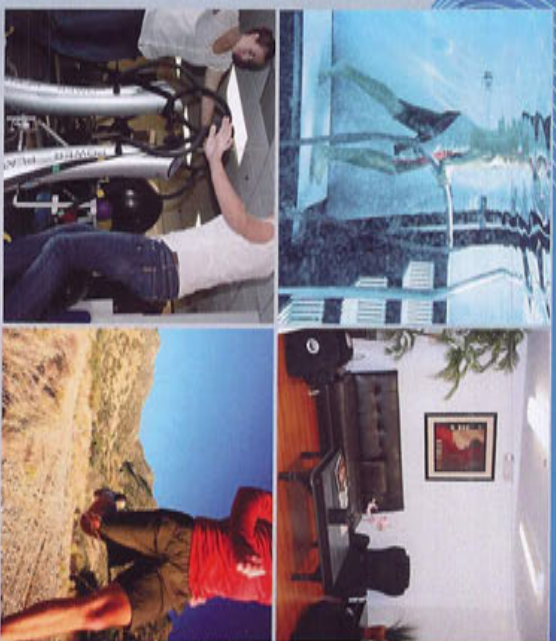


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9201 W. Sunset Blvd. Suite M120 West Hollywood, CA 90069
www.Back2HealthPT.com



"THE KNOWLEDGE AND TOOLS TO GET YOU BACK TO WORK, BACK TO PLAY, AND BACK TO HEALTH."



SLAVA SHUT PT, DPT, MS, ATC, CSCS
IAN A. NOVOTNY PT, DPT
www.Back2HealthPT.com

THE CHALLENGE THE SOLUTION...



Back 2 Health Physical Therapy & Aquatic Rehabilitation strives to work in concert with your physician to optimize patient comfort, coordination of services, and functional outcomes. The rehabilitation course will be patient specific, account for the subtle nuances of a surgical procedure, and coincide with the timing and expected goals of you and your physician.

Back 2 Health Physical Therapy & Aquatic Rehabilitation works with a wide range of patients suffering from sports injuries, gait dysfunction, pain and weakness, in addition to providing pre and post surgical rehabilitation.



AQUATIC THERAPY



The unique environment water creates allows for faster recovery, a smoother transition from non-weight bearing to full weight bearing, and greater functional outcomes.

YOU NEED EXPERT REHABILITATION SERVICES FOR YOURSELF OR YOUR PATIENTS?

Back 2 Health Physical Therapy & Aquatic Rehabilitation provides the latest techniques in rehabilitation utilizing Doctorate level training, cutting edge technology, a brand new state-of-the-art facility, and a function based approach. Your therapy will be provided by experts in rehabilitation: Doctors of Physical Therapy and their skilled support staff of certified Athletic Trainers, Pilates instructors, and Massage Therapists.

Back 2 Health Physical Therapy & Aquatic Rehabilitation bridges the gap between medical management and functional outcomes. Skilled rehabilitation services throughout a surgical course, during preventative, reparative, post surgical, restorative, and maintenance phases ensures optimal outcomes.

Regardless of the injury or treatment you or your patients require, we will tailor a program to fit individual needs in order to get you or your patients back to work, back to play, and back to health.



SERVICES

- LAND THERAPY
- AQUATIC REHABILITATION
- SPORTS THERAPY
- DRYHYDROTHERAPY MASSAGE BED
- PERSONAL TRAINING
- MASSAGE THERAPY & PILATES

ADVANTAGES

BUOYANCY

As the body is immersed in water, the property of buoyancy reduces the weight that is placed on the joints of the body.

HYDROSTATIC PRESSURE

The pressure of water creates compression which reduces and prevents swelling that may occur with injury.

RESISTANCE

The property of water displacement as the limbs are moved through the water creates smooth, non-impact resistance.

TEMPERATURE

Elevation in tissue temperature enhances the extensibility and flexibility of muscles, ligaments, and tendons.

DESIGN

An underwater treadmill, a deep water well, underwater stairs, plyometric boxes, and resistance jets create unique stations that facilitate healing, recovery, and strengthening in a functional fashion.



Ian A. Novotny PT, DPT Vladislav Shut, PT, DPT, MS, ATC, CSCS

(323) 708-6200 Phone (866) 774-9459 Fax

PATIENT INFORMATION FORM

TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____
(FIRST, MIDDLE, LAST)

I PREFER TO BE CALLED: _____ EMAIL: _____

SOCIAL SECURITY #: _____ SEX: M or F MARITAL STATUS: S M W

MAILING ADDRESS: _____
Street City Zip

HOME PHONE: () _____ WORK PHONE: () _____

CELL PHONE: () _____

PATIENT'S EMPLOYER: _____

EMPLOYER ADDRESS: _____

OCCUPATION: _____

SPOUSE'S NAME: _____ WORK PHONE: () _____

SPOUSE'S EMPLOYER: _____

EMERGENCY CONTACT & NUMBER: _____
(Other than someone living with you)

HOW DID YOU HEAR ABOUT US? Physician (Physician's Name: _____) Friend Phone Book Website Other _____



GENERAL PATIENT INFORMATION

Today's Date: _____

Name: _____ D.O.B.: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Occupation _____

Name of Referring Physician: _____

Date of most recent examination: _____

Date of next appointment with Referring Physician: _____

Please list all current medications (including nonprescription medications):

MEDICAL HISTORY

Please circle if you have had or have any of the following:

- | | |
|-------------------------------------|------------------------------------|
| 1) Heart Disease | 14) Unexplained weight loss |
| 2) Stroke | 15) Depression |
| 3) Respiratory Problems | 16) Nausea/vomiting |
| 4) Diabetes | 17) Numbness |
| 5) Arthritis | 18) Weakness |
| 6) Allergies | 19) Fainting |
| 7) High Blood Pressure | 20) Dizziness |
| 8) Fever/Chills/Sweats | 21) Night pain |
| 9) Cancer | 22) Shortness of breath |
| 10) Changes in bowel/bladder habits | 23) Sexual difficulty |
| 11) Changes in eating pattern | 24) Smoking and/or substance abuse |
| 12) Changes in sleeping pattern | 25) Mental illness |
| 13) HIV/AIDS | |

Please include additional information about circled items for clarification:



Have you ever had surgery? If yes, please list all surgeries and dates:

NATURE OF SYMPTOMS

1) Chief complaint: _____

2) Severity of discomfort at present time (please rate by circling the appropriate number):

0 1 2 3 4 5 6 7 8 9 10

No pain

Worst pain you have ever experienced in your life

3) Onset

a. WHEN did your pain begin (Please provide date) _____

b. Was the onset of your pain sudden _____ gradual _____ other _____?

c. WHERE and how did it begin (activity and specific cause)

d. Which of the following describes your problem?

Worse _____ Better _____ Not Changing _____

e. Just before this onset, were you completely free of discomfort where you have it now?

f. If not, please list the date and cause of injury and duration and treatment of prior episodes.

BEHAVIOR OF SYMPTOMS

1) Which of the following describes your discomfort? Constant _____ Intermittent _____

a. If intermittent, how often does it recur? _____

b. When it recurs, how long does it last? _____

c. How long can you be free of discomfort? _____

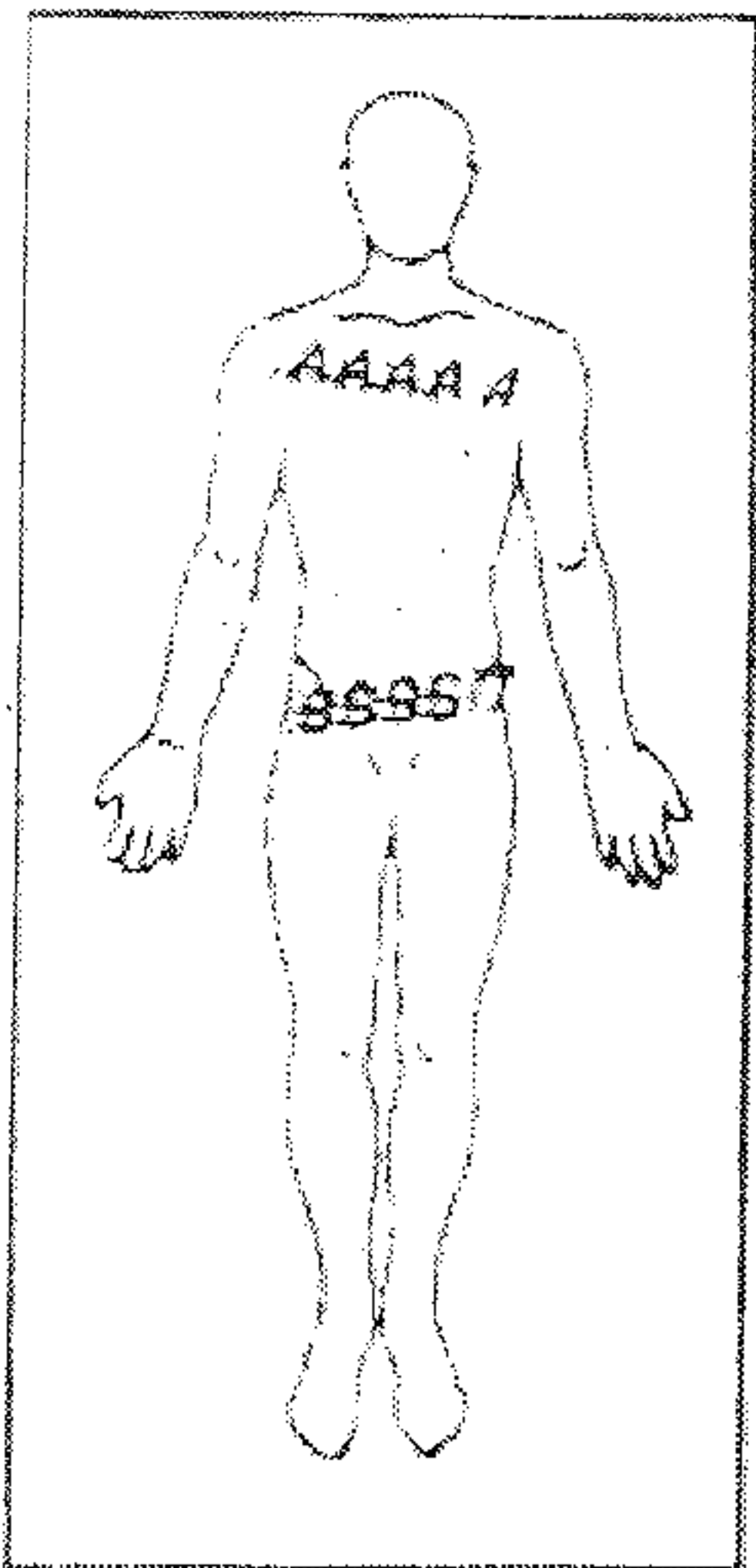
2) What activities or positions aggravate your problem?

3) Functionally, what activities are difficult to do because of your problem (i.e. vacuuming, brushing hair, climbing stairs, etc): _____

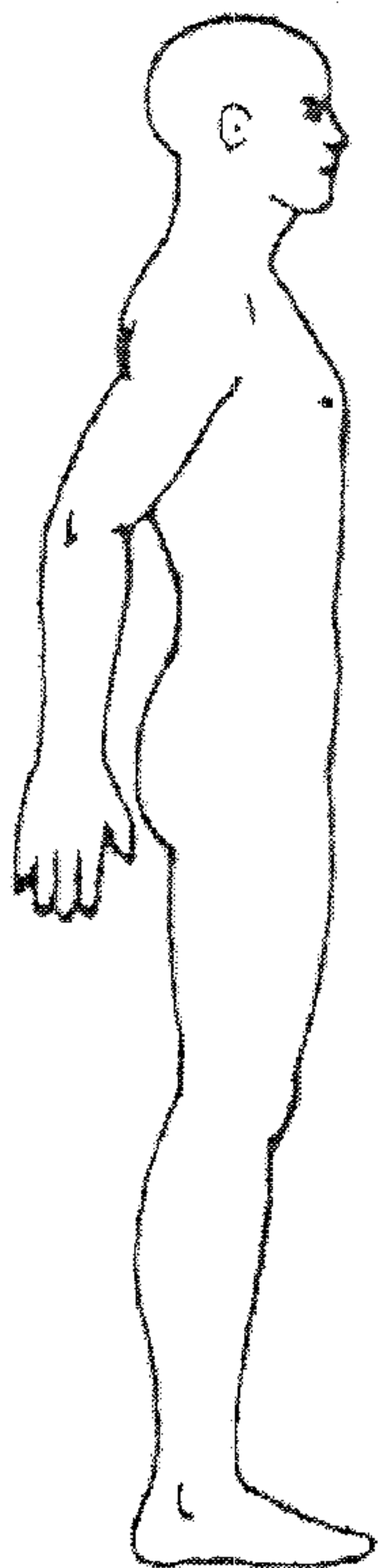
8) Location:

a. Present: Exactly where is your discomfort? Mark the areas on the body diagrams that represent the location of your symptoms. Draw the following symbols onto the body diagrams to indicate the location and intensity of pain or numbness.

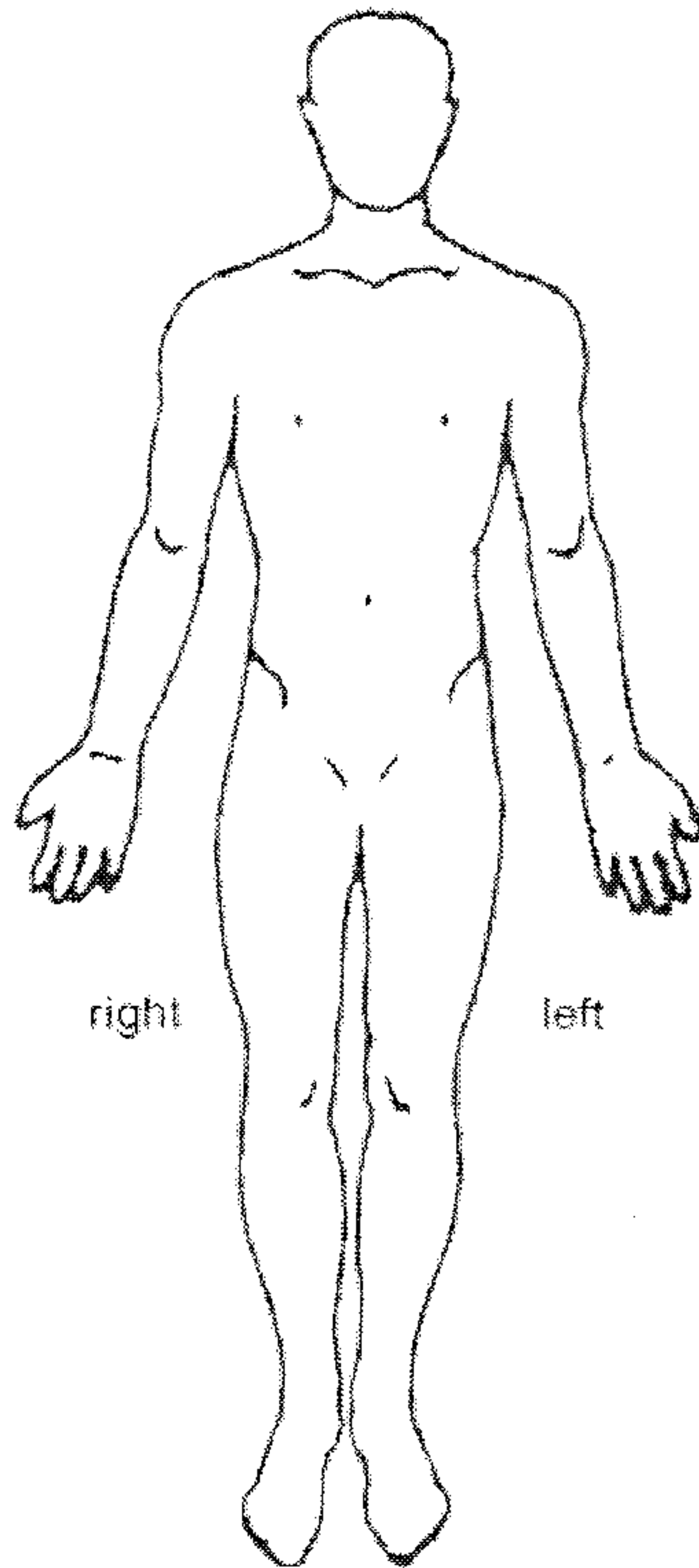
√√√ Minimal to Moderate Pain / □□□ Severe Pain / →→→ Radiating Pain / xxx Numbness



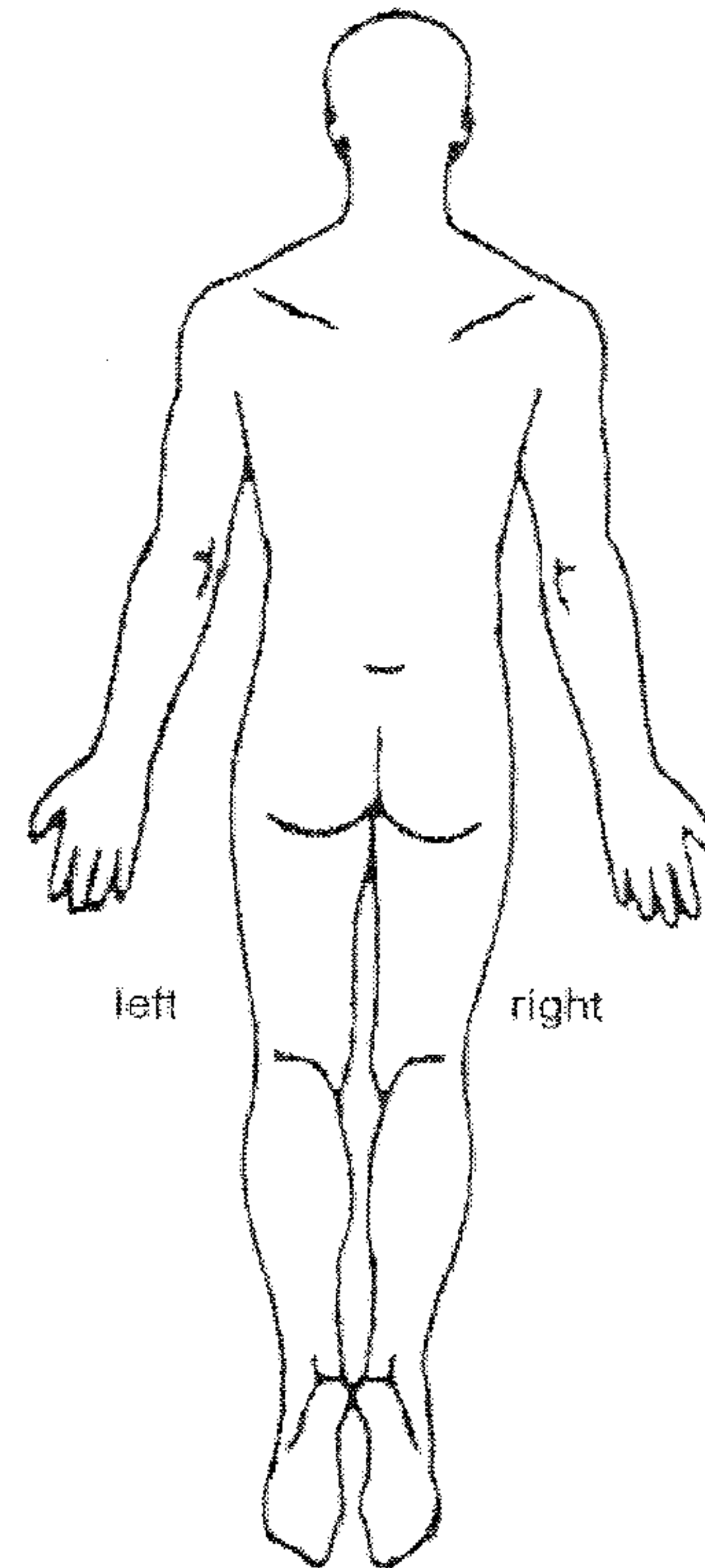
Example



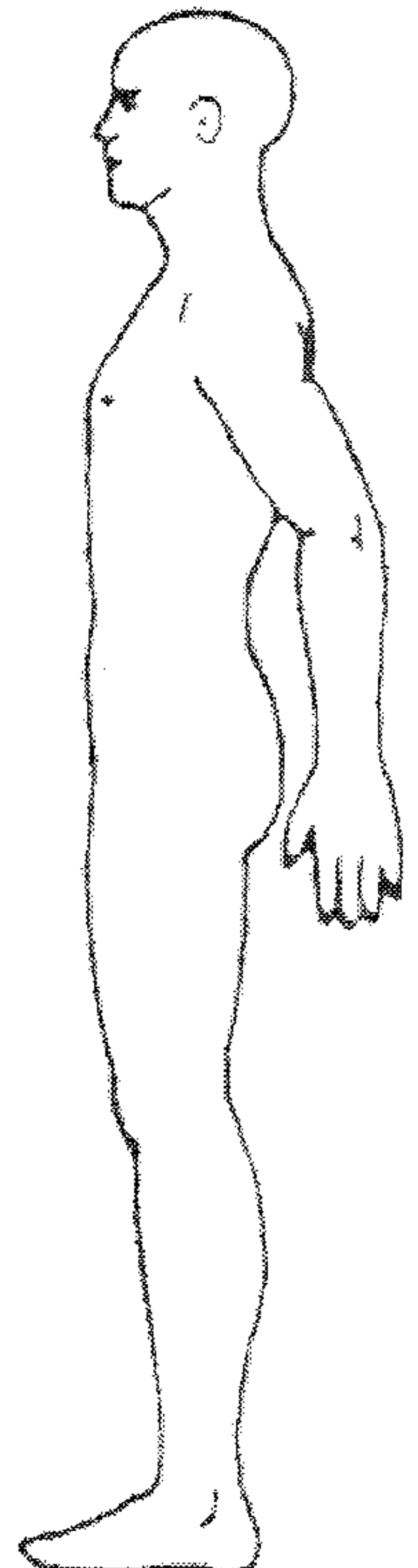
Right



Front



Back



Left



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CONSENT FORM

The following is a list of modalities and procedures used in physical therapy. Your physical therapist will explain which ones will be used during your treatment, discuss treatment alternatives and goals of treatment with you.

Evaluation
Ultrasound
Electrical Stimulation
Massage and Muscle Release Techniques Traction
Postural Training
Therapeutic Exercise
Functional training
(Body mechanics, Activities of Daily Living)

Joint Mobilization
Joint Manipulation
Muscle Stretching

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Our office employs both male and female therapists. Please communicate with our office staff if the gender of your therapist is important to you.

Comments: _____

Consent For Treatment

I give my consent for treatment by the health care professional staff of Back 2 Health Physical Therapy to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Back 2 Health Physical Therapy. I further understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to the results of treatment.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____



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Dear Patient,

Positive verification of your insurance cannot be made at this time. You will receive services today with the understanding that in the event our coverage is not effective, you will be billed and held financially responsible for these services. Additionally, you agree to be financially responsible for services provided that are not a covered benefit of your insurance plan.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

Street

City

State

Zip

HOME PHONE: _____ WORK PHONE _____

Please be advised that we are only an in-network provider for Medicare, Blue Shield, Blue Cross, Blue Cross/Blue Shield, Aetna, Cigna, United Healthcare, Great-West, Health Net and First Health.

Our current charge for services provided is \$100 per visit. In the event, you are not covered by insurance for any reason you will be financially responsible for this amount per visit.

Please note if you have financial hardship, please inform us and we will try to work out a payment plan that is better for you.

I HAVE READ THE ABOVE AND UNDERSTAND THE POTENTIAL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED DURING THIS CURRENT CALENDAR YEAR AND HEREBY AFFIX MY SIGNATURE IN ACKNOWLEDGEMENT OF THIS UNDERSTANDING.

PATIENT'S SIGNATURE _____ DATE: _____



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Financial Assignment and Release

I, the undersigned have insurance coverage with _____ and assign directly to **Back2Health Physical Therapy** all medical payments and benefits otherwise payable to me for services rendered. I hereby authorize release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

I understand that if for any reason, my insurance does not pay for the treatment I receive from **Back 2 Health Physical Therapy**, I am financially responsible for the denied services. In the event that **Back 2 Health Physical Therapy** arranges a payment plan at the start of treatment, and I discontinue treatment before the end of the plan term, I will be held financially responsible for all services rendered by **Back 2 Health Physical Therapy**, and will be billed in full for these services. The fee for services at Back 2 Health Physical Therapy is \$100.00 per visit.

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to **Back2Health Physical Therapy** for any services furnished by that provider. I authorize the holder of any medical information about me to release to **Back2Health Physical Therapy** and its agents any information needed to determine those benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, co-insurance and non-covered services.

I hereby acknowledge that I completely and fully understand the above. If I do not fully understand English, I acknowledge that this information has been adequately translated to me.

Patient Signature: _____

Date: _____



Cancellation Notice

Patient care is our #1 priority, and we will make every effort to accommodate your schedule. In order for us to be able to continue offering an open schedule, please be advised that if you cancel your appointment less than 24 hours in advance you will be charged for the visit.

I understand that I will be charged for a visit if I cancel less than 24 hours in advance.

Print Name: _____

Date: _____

Signature : _____