Rascal Creek Physical Therapy

_____
RCPT Account Number

Patient Name_____ Home Phone_____
Last First MI

Address_____ Cell Phone #_____
Number/Street City Zip

Can we leave a message on home phone? □ Yes □ No

Cell Phone? □ Yes □ No Can we use text messaging? □ Yes □ No

Birthdate_____ Age_____ Sex_____ Marital Status _____Date of Injury_____

Social Security Number_____ E-Mail Address_____

Can we notify you about appointments via e-mail? □ Yes □ No

Private Insurance Carrier_____
Please present your current insurance cards for us to copy.

Name of Subscriber_____ Birthdate of Subscriber_____

Secondary Insurance Carrier_____

Name of Subscriber_____ Birthdate of Subscriber_____

Workers' Comp Carrier_____ Claim Number_____

Patient Occupation_____Employer_____

Employer's Address_____Phone_____

Referred by Doctor_____ Family Doctor_____

Emergency Contact_____Phone_____
Name Relationship

May we discuss your medical condition or billing with another person? □ Yes □ No

Name_____ Phone_____

Is there someone we can thank for telling you about Rascal Creek PT?_____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above. I agree to permit all necessary insurance billing for such treatment. In the event that I have a financial obligation for these visits, I agree to pay all charges for me, and members of my family shown on the statements, promptly upon presentation thereof, unless credit arrangements are otherwise agreed upon in advance. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

It is agreed that payments will not be delayed or withheld because of insurance coverage or the pedency of claims thereon. All proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

Agreement: The above information is warranted to be true.

Signature_____Date_____
Responsible person

Rascal Creek Physical Therapy

Name _____Date _____

Ht. _____ Wt. _____ Involved side: Right Left Both

When did symptoms start? _____

Did you injure yourself? ❑ Yes ❑ No

How? _____

_____

What is your most significant symptom? (Circle most significant symptom)

Pain Swelling Instability Dysfunction Giving Way

Other _____

List any previous treatment for this problem:

_____

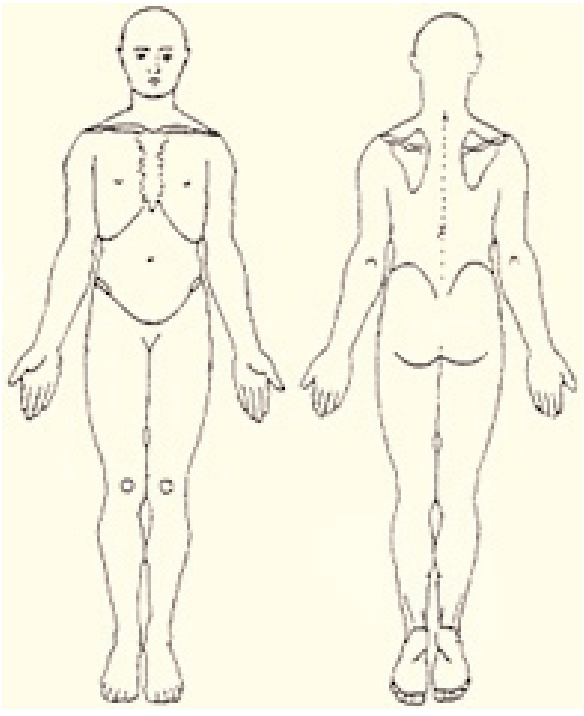
_____

_____

Have you had a previous injury of similar episode? ❑ Yes ❑ No

If yes, when? _____

On this body chart, mark the main site of pain with RED ink. If the pain spreads, mark the area where it spreads with BLACK ink.



Thanks for the information. Your therapist will have lots more questions and will be ready to answer your questions during this first visit.

Rascal Creek Physical Therapy General Health Questionnaire

Name:_____

Do you currently have or ever had any of the following conditions or diagnoses?
Check all that apply.

General Medical Conditions

___Arthritis (rheumatoid / osteoarthritis)
___Allergies (seasonal, drug, other)
___Neurological Disease(i.e. MS, Parkinson's
___Headaches
___Gastrointestinal Disease(ulcer, hernia, kidney, reflux, bowel, liver, gall bladder)
___Visual Impairment (such as cataracts, glaucoma, macular degeneration)
___Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis
___Hepatitis / AIDS
___Osteoporosis
___Anxiety or Panic Disorders
___Depression
___Previous serious accidents
___Bladder, Prostate, or Urination problems
___Incontinence
___Hearing Impairment (very hard of hearing, even with hearing aids)
___Sleep Dysfunction
___Prosthesis / Implants (metal)
___Cancer

Heart Disease

___Congestive heart failure (CHF)
___High blood Pressure
___Heart Attack (Myocardial infarction)
___Atherosclerotic Disease (CAD)
___Angioplasty
___Angina
___Valvular Disease
___Stents
___Arrhythmia
___Coronary Artery Bypass Graft (CABG)
___Pacemaker

Lung Disease

___Chronic Obstructive Pulmonary Disease
___Emphysema
___Asthma
___Recent Pneumonia

Vascular Disease

___Peripheral Arterial Disease
___Chronic Bronchitis
___Hypertension
___Are you taking Blood Pressure Medication
___Acquired Respiratory Distress Syndrome(ARDS)
___Stroke / TIA
___Diabetes

Other / Please describe:

_____

List Recent Surgical Procedures:_____

_____

Current Medications: **Reason for taking**

_____

_____

_____

Signature: **Date:**

Rascal Creek Physical Therapy, a P.C.
3327 M Street, Suite A
Merced, CA 95348

Pt:_____
SS# or DOB_____

PAYMENT POLICY

1. The patient is fully responsible for payment of all charges regardless of insurance or lawsuit determination. Payment by cash, check, Mastercard, or Visa is acceptable. All charges over 90 days are to be paid in full by the patient unless prior arrangements are made.
2. Health insurance patients will have a bill sent directly to their primary insurance carrier. The patient is responsible for supplying us with any additional forms required. We must also have a signed Assignment of Benefits on file so payments are made directly to Rascal Creek Physical Therapy. We will make every attempt to determine patient's liability in advance but ultimately, payment in full is the patient's responsibility. Any co-payment required by insurance will be billed to the patient weekly and is due upon receipt. Any overpayment on the account when all transactions are completed will be refunded to the patient and the appropriate insurance company.
3. We are an approved Medicare provider and accept assignment. Secondary insurance, if applicable, will be billed as a courtesy. Make sure you understand Medicare limitations and restrictions when beginning treatment. We do not have all the answers but we will help as much as we can.
4. Personal injury cases are handled in the same manner as our Health Insurance cases. We will bill insurance upon request. If the claim is disputed or denied, the patient is fully responsible for the balance on the account. An attorney lien will NOT be accepted on these cases; however, if another insurance is available, we will bill at time of service with information provided.
5. Workers' Compensation cases will be billed directly to the employer's compensation carrier. Workers' Comp patients are expected to provide the correct name, address and adjuster of carrier, claim number, employer and address, date of injury and attorney if applicable at time of first visit. In the event of a denied claim the patient may be held responsible for any unpaid charges.
6. Secondary insurance carriers and Medicare supplemental insurance carriers will be billed upon receipt of explanation of benefits. Overpayment from dual coverage will be refunded to the appropriate insurance carrier. This is a courtesy billing and the patient will be responsible for any co-payment.
7. Rebilling charges of up to 1.5% per month may be added to delinquent accounts with no payment received for 30 days. Keep account current or make prior arrangements to avoid additional charges. Overdue accounts will be turned over for collections if necessary.
8. We appreciate your cooperation and are here to help you. If you have any questions, don't hesitate to ask now.

Signature_____Date_____

Rascal Creek Physical Therapy
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY. This is the patient's copy of our policy.

Rascal Creek Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Rascal Creek Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Rascal Creek Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Rascal Creek Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Rascal Creek Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Rascal Creek Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Rascal Creek Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Rascal Creek Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Rascal Creek Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Rascal Creek Physical Therapy
Tony Hernandez, DPT
3327 M St. Suite A, Merced, CA 95340
Telephone: (209) 722-1030

Rascal Creek Physical Therapy

Patient Information Acknowledgement Form

I have read and fully understand the Rascal Creek Physical Therapy (hereafter RCPT) Notice of Information Practices. I understand that RCPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and for any administrative operations related to treatment or payment. In addition, RCPT has my permission to use my demographic information for purposes of announcements, statistics, marketing surveys and birthday cards. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify RCPT. I understand that RCPT will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes noted in the RCPT Notice of Information Practices. I consent to the use of my demographic information for purpose as noted. I understand that I retain the right to revoke this consent by notifying RCPT in writing at any time.

_____

Patient Name

_____

Signature

_____

Date