PHYSICAL THERAPY SPECIALISTS
EST. 1994

New Patient Intake

Please complete this form in its entirety.

PATIENT

Prefix: DR MR MISS MS MRS **Name:** _____
First MI Last Suffix

Birthdate: _____/_____/_____ **Nickname:** _____

Mailing Address: _____
Street City State Zip

Physical Address (if different): _____
Street City State Zip

Primary: HOME CELL **Phone:** Home: _____ Cell: _____

Patient's SSN: _____-_____-_____ **Gender:** M F **Driver's License Number:** _____

Marital Status: DIVORCED SEPARATED SINGLE MARRIED WIDOWED

Employment Status: ACTIVE MILITARY FULL TIME PART TIME RETIRED SELF EMPLOYED UNEMPLOYED

Employer: _____ **Student Status:** FULL TIME PART TIME NOT A STUDENT

Emergency Contact: _____ **Phone:**_____
First Last
(Please circle one)

Relationship: _____ This person has permission to discuss my care/account: **YES** **NO**

INSURANCE

Primary: _____ **Subscriber is:** SELF SPOUSE PARENT OTHER

Secondary: _____ **Subscriber is:** SELF SPOUSE PARENT OTHER

Tertiary: _____ **Subscriber is:** SELF SPOUSE PARENT OTHER

Are you a member of a union? YES NO

POLICYHOLDER - (IF DIFFERENT THAN PATIENT)

Subscriber Name: _____
First MI Last Suffix

Address: _____
Street City State Zip

Subscriber Phone: _____ **Birthdate:** _____/_____/_____ **Gender:** M F

Subscriber SSN: _____-_____-_____

PARENT/GUARDIAN - (FOR MINORS ONLY)

Parent/Guardian Name: _____
First MI Last Suffix

Address: _____
Street City State Zip

Guarantor Phone: _____ **Birthdate:** _____/_____/_____ **Gender:** M F

Parent/Guardian SSN: _____-_____-_____

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Medical History

In order to provide you with the highest quality of care, please complete this medical questionnaire thoroughly.

INJURY DETAILS

Which body part are you seeking treatment for today: _____ **Side:** LEFT RIGHT

Was your condition caused by some form of accident? YES NO **Do you have an open claim?** YES NO

Type of accident: WORK AUTO OTHER: _____ **Date of injury:** _____/_____/_____

Have you received any of the following services <u>this calendar year</u>?

Home Health Care	YES	NO	Occupational Therapy	YES	NO
Physical Therapy	YES	NO	Chiropractic Care	YES	NO
Speech Therapy	YES	NO	Surgical Procedures	YES	NO

Have you had any hospital admissions <u>this calendar year</u>? YES NO **If yes, why?** _____

MEDICAL HISTORY

Do you now or have you ever had any of the following:

High Blood Pressure	YES	NO	Sensitivity to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Cancer	YES	NO

If you are currently taking any medications, please list below or attach the types, dosages, and frequency:

_____

Please list any drug or material allergies you have: _____

Female patients only, please indicate if you are currently pregnant: YES NO

Please indicate if you need assistance with any of the following:

Transportation	YES	NO	Personal Care	YES	NO
Shopping/Errands	YES	NO	Other:		
Domestic Chores	YES	NO	_____		
Meals	YES	NO			

Please indicate if your condition caused any of the following:

Financial Problems	YES	NO	Other:		
Emotional Problems	YES	NO	_____		
Family Problems	YES	NO			

I hereby authorize Physical Therapy Specialists to render treatment and, on my behalf, accept payment directly from my insurance. I understand that benefits are coordinated between my insurance company and myself, not between my insurance company and Physical Therapy Specialists. By signing below, I understand that I will be financially liable for any services rendered which are not covered or paid by my insurance plan due to false statements, benefit coordination discrepancies, plan limitations, or benefit exclusions. The above information is true and correct to the best of my knowledge.

_____ _____

Signature of Patient Date

Appointment Policy

Please review this form in its entirety.

This may be your first contact with the physical therapy profession. In brief, our therapists are educated and trained professionals who treat physical dysfunctions and provide orthopedic rehabilitation.

Your physician has referred you to physical therapy with a given diagnosis. Based upon this referral, our therapists will perform an evaluation, develop a treatment plan, and treat your injury or disease. Your status will continually be reassessed and your treatment will progress accordingly. During your physical therapy care, you will be asked to perform certain activities at home. It is very important that you carefully follow the instructions given and perform the activities as they will ensure a quicker recovery.

TREATMENTS are by appointment only. Please call our office at (805) 473-7499 to schedule or change an appointment. We do not automatically schedule your appointments. Our office hours are from 8:00am – 6:00pm Monday through Friday. Our treatment hours vary during the hours of 7:00am – 6:00pm.

It is extremely important to be prompt and keep your scheduled appointments. **Patients arriving 15 or more minutes late will be rescheduled and a $45 missed appointment fee will be assessed.** In consideration of other patients requiring care, and with our limited staff and facilities, we require advance notice for any appointment cancellation. We have an answering machine for your convenience during non-working hours, weekends, and holidays. Our office does not provide appointment reminder calls.

It is a requirement that we notify your physician, nurse case manager, insurance company or Worker's Compensations Carrier of poor attendance for physical therapy care. **APPOINTMENT CANCELLATION POLICY** is as follows:

- You may **RESCHEDULE OR CANCEL** your appointment without fee any time **BEFORE THE CLOSE OF BUSINESS THE DAY PRECEDING** your appointment.
- Should you neglect to notify PTS by **THE DAY PRECEDING** your appointment, you may be charged **$45 FOR YOUR MISSED VISIT** which may be due prior rescheduling. This is **not** billable to your insurance under any circumstance.
- **TWO NO SHOWS OR CANCELLATIONS** without proper notice may result in discharge of your care and referral back to your physician.

OUR PRIMARY GOAL is to provide you with the highest quality physical therapy care possible. We can best assist you throughout your care when all scheduled visits are attended. I have read the above and understand my obligations as a patient.

_____ _____

Signature of Patient Date

Notice of Privacy Practices

We are required by law to provide you with information regarding your rights and the privacy practices of PTS. We are committed to maintaining the privacy of your protected health information. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by PTS. PTS may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the patient (or the patient's personal representative) authorizes in writing.

We are permitted by certain laws to use and disclose your medical information without your authorization for the following purposes or situations: (1) To the Patient (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. We will always practice professional ethics and best judgment in deciding which of these permissive uses and disclosures to make. Records may be stored by paper or stored electronically.

PTS must obtain written consent for any use or disclosure of protected health information that is not for treatment, payment, health care operations, or otherwise permitted or required by the Privacy Rule. If you authorize PTS to disclose and/or discuss your protected health information, including appointments and billing, to another individual, please provide their information below:

_____ _____

Printed Name of Authorized Individual | Relationship

The Privacy Rule requires PTS to treat a "personal representative" the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule. A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when PTS has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, it will be at the discretion of PTS to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

If you have any questions or concerns regarding your protected health information or this notice, please contact our office at (805) 473-7499. If you believe your rights have been violated, you may submit a formal written complaint to our office at P.O. Box 2638, Pismo Beach, CA, 93448-2638.

By signing below, you acknowledge you have read and understand the aforementioned, and are authorizing PTS to initiate appeals with your insurance pertaining to care received at this facility.

_____ _____

Signature of Patient | Date

_____ _____

Printed Name of Legal Representative | Relationship

Patient Rights

♦ Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information. PTS may deny an individual access in certain specified situations, such as when we believe access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion. Under HIPAA §164.524, you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed. HIPAA allows 30 days for a provider to respond to a request for records, with one 30-day extension for good reason. In accordance with California Health & Safety Code §123100, a record preparation fee of $4 plus $0.25/page will be charged. Government issued photo ID will be required of the individual picking up records.

♦ You have the right to request that PTS amend their protected health information when that information is inaccurate or incomplete. If PTS accepts an amendment request, we will make reasonable efforts to provide the amendment to persons that the individual has identified as needing it, and to persons that the covered entity knows might rely on the information to the individual's detriment. If the request is denied, we will provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. Additionally, PTS will amend protected health information upon receipt of notice to amend from another health care provider.

♦ Individuals have a right to an accounting of the disclosures of their protected health information by PTS. We are not obligated to account for any disclosure made prior to the date at the bottom of this notice. The Privacy Rule does not require accounting for disclosures as permitted by law.

♦ Individuals have the right to request that PTS restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individual's health care or payment for health care, or disclosure to notify family members or others about the individual's general condition, location, or death. All requests will be reviewed and approval will be at the discretion of PTS. PTS is under no obligation to agree to requests for restrictions.

♦ An individual may request that PTS communicate with the individual through a designated address or phone number.

As a courtesy, PTS will bill your insurance and provide necessary documentation for the processing of claims. As required by law, PTS must have policies in place to prevent insurance fraud. Therefore, it is our policy to obtain a government issued photo ID from the patient (or the parent/guardian of a minor), to be scanned with the patient's insurance card. Acceptable forms of identification can include a driver's license, state issued ID card, passport, etc. Patients may refuse to comply, however, we will be unable to bill your insurance. Alternatively, you may receive treatment as a self-pay patient at the rate of $160 for an evaluation, and $90 for each follow-up visit. Payment for services will be due in full at the time of each check-in.