PATIENT INFORMATION

First Name: ____________________________ Last Name: ________________________________ Gender: _______

DOB: ____________ Address: ____

City: ___________________________________State: ___________________________ Zip: ___________________

Home Phone: ___________________________ Cell: _________________________ SSN: _______-_______-_______

Employer: ____ Phone: ____________________________

Emergency Contact: ____ Phone: ____________________________

MEDICAL INFORMATION

Referring MD: ______________________________________ Date of Onset of Injury: _________________________

Is this a: Work injury? Yes _____ No _____ Auto accident? Yes _____ No _____

Did you have surgery? No [ ] Yes [ ]

If yes, type of surgery and date: ____

PRIMARY INSURANCE

Type of Insurance: [ ] Private [ ]Work Comp [ ]Medicare [ ]Medicaid [ ]Self Pay [ ]Lien

Person Insured: [ ]Self [ ]Spouse [ ]Other___________________

Name of Insured: ____ DOB of Insured: ______________________

Ins company: ________________________________ ID#/Claim#: _______________________

Group #: _____________________ Phone #: ________________________

SECONDARY INSURANCE

Type of Insurance: [ ] Private [ ]Work Comp [ ]Medicare [ ]Medicaid [ ]Self Pay [ ]Lien

Person Insured: [ ]Self [ ]Spouse [ ]Other___________________

Name of Insured: ____ DOB of Insured: ______________________

Ins company: ________________________________ ID#/Claim#: _______________________

Group #: _____________________ Phone #: ________________________

Signature: ____ **Date:** ______________________________________

Orthopedic And Sports Physical Therapy

Certified Hand Therapy

Aquatic Therapy

PATIENT INFORMATION AND AGREEMENT

Fees and Insurance: If a patient has medical insurance, this office will bill the insurance carrier. Verification of insurance coverage and limits, as well as approvals for industrial injury cases are performed routinely by this office. All charges are ultimately the responsibility of the patient regardless of insurance coverage, unless, the carrier is worker's compensation. If the worker's compensation, by their determination, denies the claim the patient will then be responsible. It is the policy of High Desert Therapists, Inc, and Pacific Coast Therapists to collect co-payments, co-insurances, and deductible amounts at the time of the service. Patient that do not have insurance are required to pay in full at the time of service.

Release of Information: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, this office may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, the patient's employer, health care providers and utilization review monitoring organizations.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the amount of High Desert Therapists charges. Should the account be referred to an attorney or collections agency the undersigned shall pay actual attorney's fees and collection expenses. All accounts may bear interest at the legal rate.

Appointments: If a cancellation is necessary, an attempt will be made to schedule another appointment the same day so the recommended number of weekly appointments can be kept. Should treatments involve an industrial injury, this office is required to notify the industrial carrier of any missed appointments.

Please sign below to acknowledge understanding and agreement with the policies:

______________________________________ ________________________________

Signature of patient/legal representative Print name of person signing

____

Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____ D.O.B ________________________

Previous Name: ____ SSN: _________________________

This request and authorization applies to:

__X__ Physical and/or Occupational Therapy Medical Records

_____ Health care information relating to the following treatments, condition or dates:

____

_____ All healthcare information: ____

I request and authorize High Desert Therapists, Inc or Pacific Coast Therapists to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: __________________________ State: __________________________ Zip: _______________

Your Rights:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time by signing the revocation section of this form and returning it to this office.
- My revocation will be effective upon receipt, but will not have an impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization. I this box [ ] is checked, a copy was requested and received. Initials: _______
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

Continued on the next page

Signed: ____ Date: __________________________

Printed Name: ____ Phone #: ____________________

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Other (please specify): ____

REVOCATION SECTION:

_____ I hereby revoke this authorization.

Signature: ____ Date: ________________________

Printed Name: ______________________________________ Phone #: _____________________

CONSENT TO ALLOW TREATMENT

I am aware of my diagnosis and wish to receive treatment at High Desert Therapists or Pacific Coast Therapists. I permit/authorize its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

Signature: ____ Date: ________________________

Printed Name: ______________________________________

NOTICE OF PRIVACY

On April 14, 2003, the federal government created "Privacy Rules" that all healthcare providers must comply with in order to properly protect your health information. We want to assure you that have taken the appropriate measure to comply with these rules, have provided training to our employees regarding these measures, and utilize computer security measures as well.

These regulations protects virtually all patients information regardless of where they live or where they receive their health care. All health information including paper records, oral communications, and electronic communications (such as email and electronic claims submission) are protected by the privacy rule. The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute.

The "Notice of Privacy Practices Summary" is available for you to read. It contains important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about this notice. You may contact our office during all working hours; 775-883-4161 (Nevada) or 831-786-9000 (California)

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have received and reviewed the summary of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that High Desert Therapists/Pacific Coast Therapists is not always required to agree to the restrictions I request. I also understand that I may request and obtain a full copy of the Notice of Privacy Practices.

______________________________	______________________________
Signature of Patient or Legal Representative	Witness
______________________________	______________________________
Printed Name of Person Signing	Date

ATTENDANCE EXPECTATIONS AND CANCELLATION POLICY

It is our mission to provide you with the highest quality of care.

We strive to meet or exceed your expectations in every area of service we provide for you. We will work diligently to help you regain your desired level of function by providing you excellent patient care, submission of your claims to your insurance company in a timely fashion, and provide you with convenient appointment times.

In return, we ask that you be committed and consistent with your therapy appointments and compliant with your home program. It is in your best interest to work cooperatively with your therapist in hopes of achieving your goals. We understand that situations arise that may cause you to miss a scheduled therapy appointment, but we ask for consistent communications and ask that you agree to the following policies:

Patient Initials:

________ If you must cancel an appointment, you will provide us with at least a 24 hour notice so that we may have time to fill the vacancy.

________ You will be subject to a $25 fee if you fail to show for your appointment without calling or providing us with less than a 24 hour notice.

________ If you fail to show for your appointment without calling, or fail to provide us with a 24 hour notice for 2 appointments, you will be placed on a “same day schedule” status. This means that you will not be allowed to schedule future appointments, but you may call on the same day that you know you will be able to attend therapy and we will do everything we can to provide you with an appointment that day.

We truly hope that you have an excellent experience with us here at

High Desert Therapists
and
Pacific Coast Therapists