Orthopedic And Sports Physical Therapy		Certified Hand Therapy Aquatic Therapy

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:** _____

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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

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Noridian Administrative Services
Medicare Part B Release of Information Request

This is an Authorization for release of Information form. Your signature on this form authorizes Medicare to release information to the person, agency, company or organization that you name below to Act On Your Behalf. The form will be on file for future Telephone, Written Correspondence, or Appeal Requests. Please be aware, that the form is not valid unless you sign and date it.

Beneficiary Information (person with Medicare)

Name: _____ Medicare #:_____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State:_____ Zip: _____

Reason You are Filling Out This Request (please check one)

_____ At the Request of the Beneficiary

_____ Other (specify reason) _____

Type of Information to be released (please check one)

_____ Release ALL information pertaining to physical/occupational therapy

_____ Only specific Information (please specify) _____

Time Frame For Information to be Released (please check one)

_____ On-going release

_____ Limited dates (give date range) _____ to _____

_____ Initials for page Page 1 of 2 (see next page)

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Person, agency, company or organization to which you are authorizing Medicare to disclose your personal medical information:

Name: High Desert Therapists, Inc, or dba Pacific Coast Therapists
Address: 2874 N. Carson Street, Suite 100, Carson City, NV 98706
60 Penny Ln, Watsonville, CA 95076
Phone/Fax: Nevada: ph: 775-883-4161 fax: 775-883-2528
California: ph: 831-786-9000 fax: 831-786-9100

I authorize the use of a copy (including electronic copy) of this form and the disclosure of my personal medical information described above. I understand refusal to authorize disclosure of my personal medical information will have no effect on my treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

_____ _____

Signature of Beneficiary or Authorized Representative **Date**

If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation. (For example, Power of Attorney or Appointment of Representative)

Please Note:
This Release of Authorization Request allows Medicare to disclose information from your records to the requested person, agency, company or organization that you authorized. Therefore, the information disclosed pursuant to the authorization may be re-disclosed by the recipient an may no longer be protected by law.

You also have a right to revoke this Release of Information by contacting our office in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to the address above.

If you have any questions regarding this form, please contact Nordian at:
1-800-633-4227

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: _____

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MEDICARE QUESTIONNAIRE

To assist with our ability to bill Medicare for our therapy services, we need to be sure that you are **NOT CURRENTLY** being treated by home health therapy (i**ncluding physical therapy, occupational therapy, nurse, or nurses aide**). Please answer the following questions:

1. Did you receive Home Health Care within the past year? Yes_____ No_____ Home Health Care is defined as anyone from a health care agency coming to your home to provide therapy, cleaning services, or taking blood pressure, etc.
    a. If YES, please list the name of the company who supplied the Home Health Care:

    _____

    b. Date Medicare released you from Home Health Care: _____

STOP: If you answered yes to the above question, Medicare must release you from Home Health Care in order for you to be seen in our office, as Medicare will not pay for Home Health Care and Outpatient Physical Therapy simultaneously.

2. Were you admitted to a Rehabilitation Center within the last year? Yes_____ No_____ If yes, to which center were you admitted?

_____

a. What date were you discharged? _____

STOP: You must have been discharged from the Rehabilitation Center in order to be seen in our office.

3. Have you been hospitalized within the past year with this problem? If yes, when were you discharged from the hospital and which hospital were you in?

_____

_____ _____

Patient Signature or Representative Date

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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

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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