PATIENT INFORMATION ACCT#_______________

SOCIAL SECURITY #_______________________ DRIVER'S LICENSE#_______________________

MARRIED SINGLE WIDOW DIVORCED

NAME ____ BIRTHDATE____-____-____ AGE______SEX_____

Last First MI

HOME ADDRESS_______________________________________ CITY_________________STATE_______ZIP__________

BILLING ADDRESS_____________________________________ CITY_________________STATE_______ZIP__________

PHONE HOME( )_______________ MOBILE( )________________ EMAIL:______________________________________

EMPLOYER____ OCCUPATION_________________________________

WORK PHONE ( )_____________________ADDRESS____

EMERGENCY CONTACT____ PHONE( )______________________

Last First MI

REFERRING PHYSICIAN

LAST SEEN MD____-___-_____ UPIN_______________ NPI_______________________________________

REFERRING PHYSICIAN____ PHONE( )______________________________

DIAGNOSIS____ICD 9 CODE___________________ **DOI**____-____-_____

Do you currently or have you in the past 6 months had home healthcare services? ____Yes ____No

Have you been hospitalized in the past 60 days? ____Yes ____ No

If yes to either question, who is your home health provider? ____

What is the discharge date for your hospitalization/home healthcare services? ____________________________________

Have you had or are you currently receiving occupational, speech or physical therapy, this year? ___ Yes ___No

If yes, who was your provider and how long did you receive these services? Name___________________________ Duration____________

MEDICAL INSURANCE INFORMATION (PLEASE PROVIDE NAME OF SUBSCRIBER AND DATE OF BIRTH)

PLEASE PROVIDE YOUR INSURANCE CARD(S)

Please provide Name of Insured and Birthdate for all plans.

SELF PRIVATE AUTO LIEN MEDICARE WORK COMP OTHER ___________

INSURANCE____GROUP#______________ ID#________________________________

NAME OF INSURED____ BIRTHDATE____/____/____ SEX___________

WORKERS' COMPENSATION / LIEN INFORMATION DOI_____-_____-_____

ADJUSTOR________________________________ CLAIM#________________________________PHONE( )__________________

AUTHORIZED BY_________________________________ DATE_________________ DURATION__________________________

ATTORNEY_________________________ADDRESS_____________________________ ______ PHONE( )_____________________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

NAME____ SOCIAL SECURITY #___________________________

Last First MI

RELATIONSHIOP TO THE PATIENT________________________________ BIRTHDATE ___/___/___ SEX_______

ADDRESS____ HOME PHONE ( )______________________

EMPLOYER____ OCCUPATION___________________________

ADDRESS____ WORK PHONE ( )______________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider of medical services and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. It is also your responsibility to know your benefits and the network status of the medical provider you obtain services from by contacting them prior to any services being rendered. Initial________________

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to ***CENTRAL COAST PHYSICAL THERAPY*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ***CCPT*** to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE____**DATE**____________________________

Central Coast Physical Therapy

PAST MEDICAL HISTORY:

Please circle any condition that you currently have or have had in the past:

High blood pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Are you allergic to latex? YES NO
Do you Smoke? YES NO
Are you Pregnant? YES NO

During the past month have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

Are you currently taking any medications? YES NO
If yes, please list ALL medications you are currently taking:

____
____
____

Please list past surgeries and dates:

____
____
____

Please list any medical conditions you have that have not been documented above:

____
____

What are your physical therapy and/or fitness goals?:

____
____

Patient signature:____**Date:**____________________

Central Coast Physical Therapy

Medical Screening Form

Name____Date:_______________

CURRENT CONDITION:

When did these symptoms start?____

How did the injury occur?: (gradually, suddenly, injury):____

My symptoms are currently: getting better / about the same / getting worse

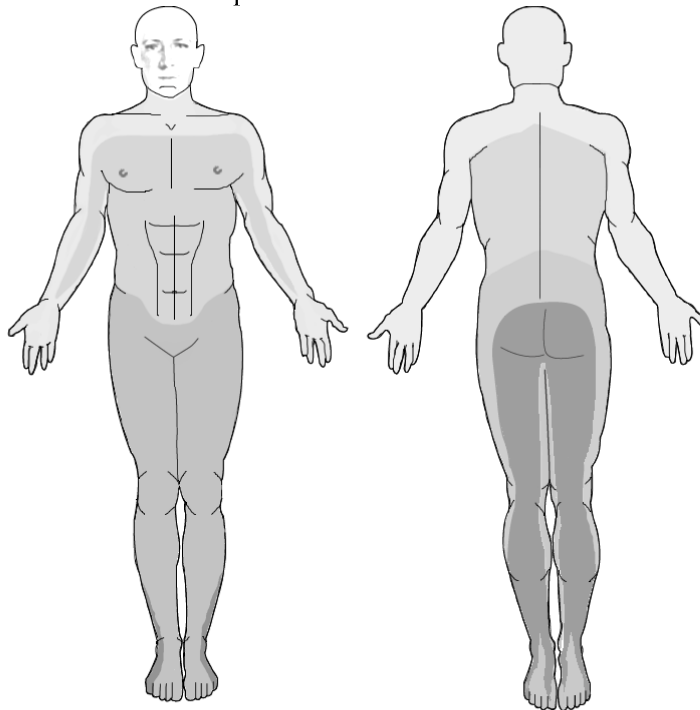
Please list any previous treatment for the condition we are seeing you for today:______________________________

Have you ever had this problem before? YES NO

If so how was the problem treated?____

Have you had any imaging studies done for this problem (x-rays, MRI, etc.) YES NO

Please use the following symbols: ^^^ Numbness *** pins and needles /// Pain



Rate your pain (1=mile, 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10
Right now: 1 2 3 4 5 6 7 8 9 10

<u>Currently I am experiencing the following (circle all that apply):</u> dizziness

Unexplained weight loss	difficulty swallowing	changes in bowel or bladder function
Increased pain at night	headaches	depression
Fever/chills/sweats	nausea/vomiting	shortness of breath
Changes in appetite	numbness or tingling	poor balance/falls

PATIENT NAME: ______________________________ **ID#:** _______________ **DATE:** ___________

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _______________

Central Coast Physical Therapy

7380 Morro Rd., Atascadero, CA., 93422

Ph: 805-462-1110 Fax: 805-462-0660

OFFICE POLICY

Consent To Treatment: I the undersigned agree to give my consent to Central Coast Physical Therapy to furnish physical therapy care and treatment services. These services include but are not limited to therapeutic test/s, treatments or procedures, manipulation, stretching, or exercise as directed under the general instructions of the Physical Therapist, Physical Therapist Assistant, or Physical Therapy Aide. I authorize my Physical Therapist(s) to take photographs relating to my physical condition as are deemed necessary.

Consent for treatment of a Minor: As parent and/or legal guardian, I authorize Central Coast Physical Therapy to treat

_______________________________________(minors name) while I am not present.

Assignment of Insurance Benefits: I hereby authorize Central Coast Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Workers Compensation Claims: If you claim workers compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Cancellation and No-Show Policy: Central Coast Physical Therapy requires a 24 hour notice in the event of a cancellation. The charge for cancellation or no-show without proper notice is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Co-Payments: Co-payments may be paid at the time of service. If your co-payment is not paid at the time of service you will be billed for your contracted co-payment.

Non-Sufficient Funds: Checks returned for non-sufficient funds may be subject to a $25 processing fee.

____ _______________

Patient/Guardian/Responsible Party Signature Date

____

Print Name

Financial Policy: We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Central Coast Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. If formal collections procedures become necessary you will be responsible for additional costs incurred. Furthermore, I understand that I cannot change my chosen payment option after services have been rendered .

☐ I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment.___________________(please initial).

☐ I choose to have Central Coast Physical Therapy bill my insurance company. It is my responsibility to understand my physical therapy benefits and coverage.________________________(please initial).

The above financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ _______________

Patient/Guardian/Responsible Party Signature Date

Account:__________

I, ____________________________ authorize Central Coast Physical Therapy, Inc. and staff to release
(Please print)
the following HIPAA regulated information to:

_________________________________ relationship________________

_________________________________ relationship________________

_________________________________ relationship________________

□ All Medical and Billing
□ Medical only
□ Billing only
□ None

I prefer to receive messages regarding my healthcare and billing via:

□ Home telephone___________________
□ Mobile phone ___________________
□ Mail

This authorization is valid until revoked by me in writing.

Signature:_______________________________ Date:______________________

Witness:________________________________

Privacy Policy Statement

01-01-2012

7380 Morro Road, Atascadero, CA 93422
805-462-1110

1421 Riverside Drive, Paso Robles, CA 93422
805-239-1202

4070 West St., Cambria, CA 93428
805-927-1055

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Purpose: *The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.*

Effective Date: *This policy is in effect as of : 01-01-2003.*

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices

It is the policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities

It is the policy of this medical practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this medical practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals

It is the policy of this medical practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information

It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

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Marketing Activities

It is the policy of this medical practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect. It is the policy of this organization to consider marketing any communication to purchase or use a product or service where an arrangement exists in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service. This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment to be marketing. Further, this organization adheres to the HIPAA Privacy Rule that a face to face communication made by us to the patient, or a promotional gift of nominal value given to the patient does not require an Authorization.

Psychotherapy Notes

It is the policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

A. Use by originator for treatment;

B. Use for training physicians or other mental health professionals as authorized by the regulations;

C. Use or disclosure in defense of a legal action brought by the individual whose records are in issue;

D Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

Complaints

It is the policy of this medical practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this medical practice that all complaints will be addressed to : *Stella Culver, PT, owner, Central Coast Physical Therapy, INC.,* , who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy and Security Rule.

Prohibited Activities-No Retaliation or Intimidation

It is the policy of this medical practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility

It is the policy of this medical practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

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Verification of Identity

It is the policy of this medical practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of this medical practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards

It is the policy of this medical practice that appropriate physical safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of this medical practice that business associates must be contractually bound to protect health information to the same degree as set forth in this policy. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

Training and Awareness

It is the policy of this medical practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this medical practice complies with the HIPAA Privacy and Security Rules. It is also the policy of this medical practice that new members of our workforce receive training on these matters within a reasonable (you may elect to enter the exact time frame) time after they have joined the workforce. It is the policy of this medical practice to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time (you may elect to enter the exact time frame) after the policy or procedure materially changes. Furthermore, it is the policy of this medical practice that training will be documented indicating participants, date and subject matter.

Material Change

It is the policy of this medical practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions

It is the policy of this medical practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any

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procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records

It is the policy of this medical practice that the HIPAA Privacy Rule records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Regulatory Currency

It is the policy of this medical practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities

It is the policy of this medical practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance reviews and investigations.

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