



PATIENT INFORMATION

Please Print

Patient Name: _____ Date of Birth: _____
Married Single Widowed Divorced Separated Social Sec. No.: _____
Home Address: _____ Home Phone: _____
City: _____ Zip: _____ E-mail: _____
Patient Employed by: _____ Business Phone: _____
Business Address: _____ City: _____
Occupation: _____ Doctor: _____
Emergency Contact: _____ Phone: _____

Learned of Office Through: Physician Yellow Pages Friend Newspaper Insurance Co. Other

Is this a work related injury? YES NO If accident/injury, is litigation involved? YES NO

MEDICARE PATIENTS ONLY: Have you in the past 3 months or are you currently receiving any type of services through a home health agency, i.e., any person coming to your home to provide any type of services? YES NO

(PLEASE BE ADVISED THAT MEDICARE WILL NOT PAY OUTPATIENT PT & HOME HEALTH SERVICES TOGETHER)

IF ANOTHER PARTY, IN ADDITION TO PATIENT, WILL ASSUME RESPONSIBILITY FOR PAYMENT OF PATIENT'S BILL PLEASE COMPLETE THE FOLLOWING: Please Note: Patient is primarily responsible for his/her bill.

Responsible Party: _____ Phone: _____
Address: _____ City: _____ Zip: _____
Employer: _____ Business Phone: _____

IF YOU HAVE MEDICAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

Name of Company: _____
Certificate or Member I.D. Number: _____ Group Number: _____
Subscriber/Insured: _____ Date of Birth: _____
Medicare Number: _____ Medi-Cal Number: _____

Remarks: _____

AUTHORIZATION TO PAY

I hereby authorize the _____ Insurance Company to pay by check made payable to and mailed directly to:

DYNAMIC PHYSICAL & HAND THERAPY, INC.
3901 E. LAS POSAS RD., SUITE 7
CAMARILLO, CALIFORNIA 93010

for the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward charges for Professional Services Rendered. This payment will not exceed my indebtedness to the aforementioned assignee and have agreed to pay, in current manner, any balance of said Professional Service charges over and above this insurance payment.

Date: _____ Signature of Subscriber or Spouse: _____



PATIENT HISTORY FORM

Name: _____ Sex: _____ Date of Birth: ___ / ___ / ___

1. Have you ever had any problems with the following?

Table with 2 columns of conditions and 2 columns of YES/NO checkboxes.

Other Illness or Explain Above: _____

2. Have you ever had surgery? YES NO If Yes, give dates & type(s)

3. Do you have any metal implants (other than teeth)? YES NO _____

4. (For Women Only) Are you pregnant? YES NO

5. Current medications (Name, Frequency & Reason): _____

6. Have any tests been taken for your current problem? (Please Circle) X-RAYS, MRI's, EMG's, NCV's, CAT SCANS, BONE SCANS, ARTHO or ANGIOGRAMS, STRESS TEST, EKG's or OTHERS

If Yes, when & who recommended them? _____

7. Current problem: _____

If result of an accident or injury, when did it occur? ___ / ___ / ___ If not, give onset: ___ / ___ / ___ & when it was diagnosed: ___ / ___ / ___

8. Have you ever had physical, social or vocational rehabilitation/clinical psychology treatments? YES NO If Yes, indicate where, when & for what problems

9. Have you in the past 3 months or are you currently receiving any type of services through a home health agency, i.e., any person coming to you home to provide any type of services? YES NO (PLEASE BE ADVISED THAT MEDICARE WILL NOT PAY OUTPATIENT PT & HOME HEALTH SERVICES TOGETHER)

DATE: _____

SIGNATURE: _____

(If not patient, indicate parent, guardian or other)



PHYSICAL & HAND THERAPY, INC.

3901 E. Las Posas Road, Suite 7, Camarillo, CA 93010
(805) 987-6851

AGREEMENT TO PAY

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE AND LIABLE FOR REPAYMENT OF ALL CHARGES ASSESSED FOR PROFESSIONAL SERVICES RENDERED ON MY BEHALF AND HEREBY EXPRESSLY AGREE TO PAY ANY AND ALL SUMS DUE UPON DEMAND.

I understand and expressly agree that my responsibility and liability is not, in any way, diminished, mitigated, eliminated, released, excused or affected by the fact that another party has agreed to assume responsibility for my bill and/or by the fact that I may have medical or other insurance which may provide coverage for the medical services being provided on my behalf.

I understand that, as a matter of accommodation and convenience to me only, billings may be submitted to other parties who may have agreed to assume responsibility for my bill as well as to my insurance company or companies. I expressly agree to fully cooperate with Dynamic Physical & Hand Therapy, Inc. in the processing of insurance claim forms. In the event that my insurance company may forward payment to me directly, instead of to Dynamic Physical & Hand Therapy, Inc., I expressly agree to immediately deliver such payment to Dynamic Physical and Hand Therapy, Inc.

I understand and expressly agree that, if my insurance does not provide for and pay 100% of the billings submitted by Dynamic Physical & Hand Therapy, Inc., I will pay any deductible portion of such billing at the time services are provided. Additionally, that portion or percentage of the charges for medical services which is not covered by my insurance will be paid by me at the time such medical services are provided on my behalf.

I understand and expressly agree that, if I or someone acting on my behalf does not provide Dynamic Physical & Hand Therapy, Inc. with **at least 24 hours advance notice** of any cancelled treatments that I will be responsible for the **\$35.00 cancellation/no show fee**, and that if I suspend or terminate my care and treatment, the fees for professional services rendered to me will be immediately due and payable.

I understand and expressly agree that an interest charge equal to 1.5% per month will be added to my bill for all charges which have not been paid in full within sixty (60) days after billing to either myself, another party who has agreed to assume responsibility for payment of my bill, or to my insurance company.

I understand and expressly agree that if it becomes necessary to commence legal action for the collection of any outstanding charges to my account, I will be responsible for and agree to pay any and all attorney fees and costs actually incurred by Dynamic Physical & Hand Therapy, Inc., in addition to the outstanding balance due on my account.

Dated: _____

Patient's Signature: _____



SOCIAL SERVICES/SUPPORT SPECIALIST SCREENING FORM

In order to provide high quality services to our patients during their rehabilitation, a Social Service/Support Specialist is available for consultation. Please complete this form so that we can better meet your needs.

1. Name: _____ Date: _____

2. Phone Number: _____

3. Do you require assistance with:

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

4. Do you have someone to assist you with household or daily tasks? YES NO

5. Has your injury/illness caused any of the following:

Financial Stress	YES	NO	Family Problems	YES	NO
Anger	YES	NO	Anxiety	YES	NO
Sadness	YES	NO	Frustration	YES	NO

6. Are you having difficulty coping with pain? YES NO

7. Do you think physical therapy or occupational therapy can improve your condition? YES NO

8. Would you like to consult with our Support/Social Service specialist? YES NO

9. Patient Signature: _____

I have reviewed the above information provided by the patient. The patient does NOT appear to require Social Service intervention at this time.

Social Worker Signature: _____ Date: _____

I have reviewed the above information provided by the patient. The patient may benefit from Social Service intervention regarding the following issues: _____

Social Worker Signature: _____ Date: _____

Comments: _____



Licensed Physical Therapist

MEDICARE PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

Statement to Permit Payment of Medicare

Benefits to Supplier, Physician or Patient:

Name of Beneficiary

Health Insurance Claim Number

I request that payment of authorized Medicare Benefits be made on my behalf to Dynamic Physical & Hand Therapy, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____
Signature of Patient

Date



MEDICARE OUTPATIENT SCREENING FORM

Dear Medicare Patient:

Medicare now requires that we screen all patients for the possibility of other coverage that would be primary over Medicare. Please answer the following questions:

- 1. Is this illness/injury due to an accident?
2. If yes, was your injury due to an auto accident or an on-the-job injury?
3. Are you between the ages of 60 and 69 years?
4. Are you under the age of 65 and entitled to Medicare based on disability?
5. If yes to 3 or 4, are you covered by an employer or large health group plan (E or LGHP) through either yourself, a spouse or family member by reason of CURRENT employment?
6. If yes to 5, does the employer employ more than 20 people?
7. Are you a member of any health maintenance organization (HMO) plan?
8. Have you in the past 3 months been admitted to an acute hospital for any condition?
9. Have you in the past 3 months or are you currently having ANY type of services through a Home Agency (not restricted to just PT), i.e., any person coming to your home to provide any type of service?

(PLEASE BE ADVISED THAT MEDICARE WILL NOT PAY OUTPATIENT PT AND HOME HEALTH SERVICES TOGETHER)

X Patient/Representative Signature

Date

If representative, what relationship?

Thank you very much for helping us comply with Medicare's requirements.

Dynamic Physical and Hand Therapy, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures We will use your protected health information (PHI) for the purpose of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health care operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Our practice may use your PHI to send you an appointment reminder and to inform you of our other health related products and services.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following way: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurance that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release PHI about you when it is determined to be necessary by the appropriate military authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request.

Updated 5/31/07

Confidential Communication

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI. If you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with federal health information privacy regulations by maintaining the privacy of you PHI. These rules require us to provide you with this document. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact.

Daniel Johnston
Privacy Office / President
3901 E. Las Posas Rd. Ste. #7
Camarillo, CA 93010
805 987-6851

Effective Date: **April 14, 2003**

Please sign below to affirm that you have received a copy of our Privacy Practices Policy

Patient Signature: _____ Date: _____