Sierra Orthopaedic and Athletic Rehabilitation

Please print in black ink

____

(Full Legal Name) Last First MI Date of Birth Occupation

Mailing Address: ____

Street/P.O. Box City State Zip Code

Residence (if different): ____

Street City State Zip Code

(______)____________________(______)____

Home Phone Work/Cell Phone Marital Status Age Gender Social Security #

Referring Physician: ____

Name of MD, DPM, DC, DO Date of injury/or onset of symptoms

1. **Is this condition related to an injury on the job? YES____ NO____ (If yes, was a claim filed? YES_____ NO_____)**
2. **Were you treated elsewhere for this injury? Chiropractic included. YES____ NO____ (If yes, No. of treatments? ______)**
3. **Is this injury related to a motor vehicle accident? YES____ NO____**
4. **Is this injury involved in litigation? YES____ NO____ (If yes, provide attorney information below)**

____ ____

Primary Insurance Company Name **Secondary Insurance Company Name**

Name of Insured: ____

(If different from Patient) (Spouse or Parent) Social Security # Date of Birth

If party is a minor: ____

Name of **Insured** Parent Social Security # of **Insured** **Insured's** Date of Birth

Workers' Comp Info: ____

Employer Name Address Phone

Litigation information: ____

Attorney Name Address Phone

FOR OFFICE USE ONLY

Insurance______________________________ID/Claim#____________________Grp#____________

Address____

Phone ( ) _______________ Fax ( ) _______________ Claim/Rep/Adjuster______________________

Eff Date__________ Ded.________ Met________ Cov%_____Chiro________Rx Req'd:_____ # of visits______________ Orthotics ___________Co-Pay______

____

2° Insurance____________________________ID/ Claim#____________________Grp#___________

Address____

Phone ( ) _______________ Fax ( ) _______________ Claim/Rep/Adjuster ______________________

Eff Date __________ Ded.________ Met________ Cov%_____Chiro________Rx Req'd:_____ # of visits______________Orthotics__________ Co-Pay______

Date Consulted ___________________ Provider: RK RT KE Diagnosis_______________________________

NP RP New Case New Diagnosis ____

Medical History

Patient Name: ____ Date:___________________________

Have you EVER been diagnosed as having any of the following conditions? If yes, briefly describe.

YES	NO	Cancer	YES	NO	Heart Problems
YES	NO	High Blood Pressure	YES	NO	Diabetes
YES	NO	Asthma	YES	NO	Lung Disease
YES	NO	Allergies	YES	NO	Joint Problems
YES	NO	Thyroid Problems	YES	NO	Kidney Disease
YES	NO	Liver Disease	YES	NO	Neurological Disease
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Depression	YES	NO	Chemical Dependency (alcohol, medication)

Do you smoke? YES NO If yes, how much, and for how long? __________________________________
Do you drink alcoholic beverages? YES NO If yes, how much and how often? _____________________
Do you have frequent or unusual headaches? YES NO Describe: ________________________________
Do you have any metal implants (joint replacements/plates/rods)? YES NO Where?________________
Do you have a pacemaker? YES NO
FOR WOMEN: Are you currently pregnant or do you think you might be? YES NO

Please list your medications (including <u>all</u> prescribed, herbal or homeopathic and over-the counter):

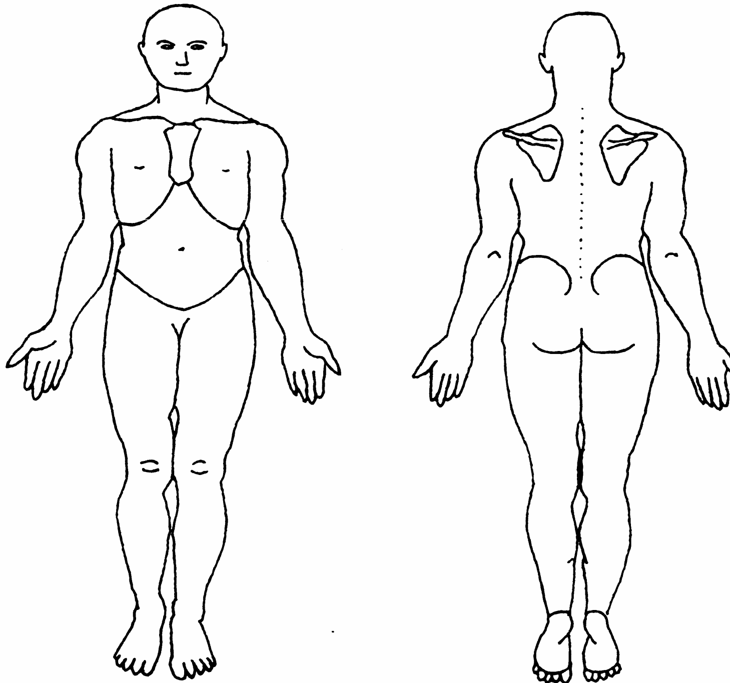
Please list any surgeries or other conditions for which you have been hospitalized, including the approximate dates:

Who is your primary care physician? ____

Have you had chiropractic or massage therapy treatments this year? YES NO If yes, by whom and when:
____

Symptoms Drawing

Please draw on the body chart where you feel problem(s) and briefly describe your symptoms (e.g.: sharp, ache, tingling, etc…) next to where you feel them.



Sierra Orthopaedic and Athletic Rehabilitation
Attendance Policies

Physical Therapy services are unique in that most patients are scheduled to attend on a frequent basis, commonly 2-3 times per week. Your doctor and therapist will make recommendations for frequency (how often) and duration (how long) you may require treatment. Consideration will be given if your insurance plan has restrictions on the number of visits allowed or requires pre-authorization. We recommend that you attend your sessions regularly for optimal benefit.

Our office hours are from 8 a.m. to 5:30 p.m., Monday through Thursday, and 8 a.m. to 4:30 p.m. on Friday. Every effort will be made to schedule your appointments as prescribed and as conveniently as possible for your personal schedule. In the event that you cannot attend a scheduled appointment, please keep the following policies in mind and initial all boxes:

☐ **24-Hour Advance Cancellation Notice Fee:** ***A 24-hour cancellation notice is required. A $20.00 fee will be charged to your account if you neglect to notify us within 24 hours.*** During non-business hours, please leave a message on our answering machine, clearly stating your name, and the date & time of your appointment. If you find it necessary to cancel more than ***three sessions in a row***, your therapist will be notified and further scheduling will be at his or her discretion. Repeated cancellations may affect your treatment outcome and are discouraged.

☐ **"No-show":** We have a ***strict "no-show" policy***. If you do not show for your scheduled appointment and have not called in to cancel, you will be marked as a "no-show". A **$*20.00 fee*** will be charged to your account and all future appointments will be removed. Further scheduling will be at the discretion of your therapist and the referring doctor.

☐ **Late arrival:** Appointments are typically scheduled on the hour and half-hour. We try as much as is possible to stay on time for your appointments. ***Late arrival (greater than ten minutes)*** may require re-scheduling if your therapist believes that your treatment will be insufficient in the remaining time period. If possible, please call (530) 344-2045 to let us know that you will be arriving late.

Please initial boxes and sign here:_______________________________Date:_________

Sierra Orthopaedic and Athletic Rehabilitation Financial Policies

Financial Policy: Patients must recognize that they are responsible for the charges incurred for physical therapy (Worker's Compensation excluded, although **prior authorization is required**). We will submit billing to your insurance, free of charge for physical therapy services. You are responsible for knowing what your benefits are. In the event your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment.

Medicare: Effective January 1, 2006, Medicare implemented a financial limitation (therapy cap) on physical therapy services. The 2011 therapy cap has been set at $1,870.00 per year, although some diagnoses are exempt.

Lien of Personal Injury Policy: If you were involved in a motor vehicle accident we will submit billing to your insurance. A lien of personal injury must be signed. A good faith payment must be paid at each visit or payment arrangements can be made prior to treatment. Any applicable co-payments will be accepted as a good faith payment.

Attorney Lien Policy: If you sustained a personal injury and retained an attorney, our office must receive a signed lien by patient and attorney by the third visit or you will be charged for each visit thereafter until signed lien is received.

Durable Medical Equipment (DME) and Custom Orthotics Policy: We do not bill for DME (Worker's Compensation excluded, although **prior authorization is required**). Medicare patients must sign an **A**dvanced **B**eneficiary **N**otice (ABN) for orthotics, since they are not a covered benefit. A deposit must be paid prior to ordering the orthotics.

Attendance Policy: We do not charge for cancelled or missed appointments. We ask that you read and agree to comply with our Attendance Policy. A copy will be given to you for reference.

Authorization and Assignment of Benefits

I hereby authorize and direct you, my insurance company, to pay directly to Sierra Orthopaedic and Athletic Rehabilitation such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and without such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the office's services provided.

Patient Information Acknowledgement

I have read and fully understand Sierra Orthopaedic and Athletic Rehabilitation's Notice of Information Practices. I understand that Sierra Orthopaedic and Athletic Rehabilitation may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sierra Orthopaedic and Athletic Rehabilitation will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of any personal health information for purposes as noted in Sierra Orthopaedic and Athletic Rehabilitation's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient signature: ____
Name Date

If party is a minor: ____
Name of Parent/Guardian Date

SIGNATURE CONSTITUTES ACCEPTANCE OF ABOVE POLICIES AND CONSTITUTES CONSENT TO TREATMENT

Sierra Orthopaedic and Athletic Rehabilitation

NOTICE OF PATIENT INFORMATION PRACTICES

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

Sierra Orthopaedic and Athletic Rehabilitation's LEGAL DUTY

Sierra Orthopaedic and Athletic Rehabilitation is required by law to protect the privacy of your personal health information, provide notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Sierra Orthopaedic and Athletic Rehabilitation uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example Sierra Orthopaedic and Athletic Rehabilitation may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Sierra Orthopaedic and Athletic Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or incidental disclosures. We also provide information when required by law.

In any other situation, Sierra Orthopaedic and Athletic Rehabilitation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Sierra Orthopaedic and Athletic Rehabilitation may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Sierra Orthopaedic and Athletic Rehabilitation will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Sierra Orthopaedic and Athletic Rehabilitation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of you personal health information, please contact our practice manager at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Sierra Orthopaedic and Athletic Rehabilitation's health information practices or if you have a complaint, please contact the following person:

Sierra Orthopaedic and Athletic Rehabilitation
Diane Pyeatt / Office Manager
4300 Golden Center Drive, Suite B, Placerville, CA 95667
Telephone: 530-344-2045   Fax: 530-642-0794