



www.eldoradopt.com

Diane Ornoski, PT, Owner
David K. Thomas, PT, MPA, Owner

El Dorado Hills (916)933.1221
907 Embarcadero Drive, 95762

Folsom (916)355.1250
990 Riley Street, 95630

Shingle Springs (530)677.5092
4242 Sports Club Drive, 95682

Central FAX (916)933.0871

Office Policy

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize El Dorado Physical Therapy to treat _____ (minor's name) while I am not present.

CONSENT FOR TREATMENT: Your Physical Therapist will complete an evaluation by interview and examination. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for El Dorado Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize El Dorado Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: We require written authorization from your Workers' Compensation carrier prior to your initial visit. If your claim is subsequently denied, you will be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$25 for a physical therapy visit. This charge will not be covered by insurance and will have to be paid by you personally prior to receiving additional treatment.

CO-PAYMENTS: Per our contracting guidelines, co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds will be subject to a \$25 processing fee.

Financial Policy

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If your bill has not been paid within 30 days from the date on your bill, a **1.5% per month FINANCE CHARGE 18% per annum** will be applied. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. Furthermore, I understand that I cannot change my chosen payment option after services have been rendered.

I choose to self-pay at a 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 UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party Signature

Date

Clinic Representative

Date

HIPAA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information, about the patient, used to carry out treatment, payment or health care operations.

We respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum amount of information needed regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. At times we may need to disclose personal health information for purposes of treatment, payment or health care operations. In such situations your consent may not be required.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under HIPAA regulations, we have the right to refuse to treat you should you choose to refuse disclosure of your Personal Health Information. If you choose to give consent in this document, you may later revoke all or part of your consent. However, this will not affect actions that have already taken place relying upon this or any other previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

As a part of your treatment we may need to administer treatment in a group setting (i.e. a common treatment area or gym). In such situations, some of your personal health information may be disclosed. We will do our best to keep disclosures to a minimum.

Please check here to refuse treatment in a group setting (treatment will be provided in a private room).

CONSENT TO PRIVATE HEALTH INFORMATION DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their private health information (PHI). The individual is also provided the right to request confidential communication, or that communications of PHI be made by alternate means, such as sending correspondence to the individual's office instead of to their home.

Please choose ONE contact method for each category. If you make more than one designation for any category, or do not make a designation, we will assume the more restrictive choice in order to guard your PHI.

HOME TELEPHONE _____

Ok to leave messages with detailed information

Leave messages with name and callback number only

WORK TELEPHONE _____

Ok to leave messages with detailed information

Leave messages with name and callback number only

CELLULAR PHONE _____

Ok to leave messages with detailed information

Leave messages with name and callback number only

WRITTEN COMMUNICATION

Ok to mail to my home address Ok to mail to my work address Ok to fax to this number: _____

If you would like to authorize El Dorado Physical Therapy to release your PHI to any other party, please specify here:

Name

Relationship

Contact Method

Print Name of Patient

Patient Signature (or Parent/Guardian if Patient is under 18)

Date

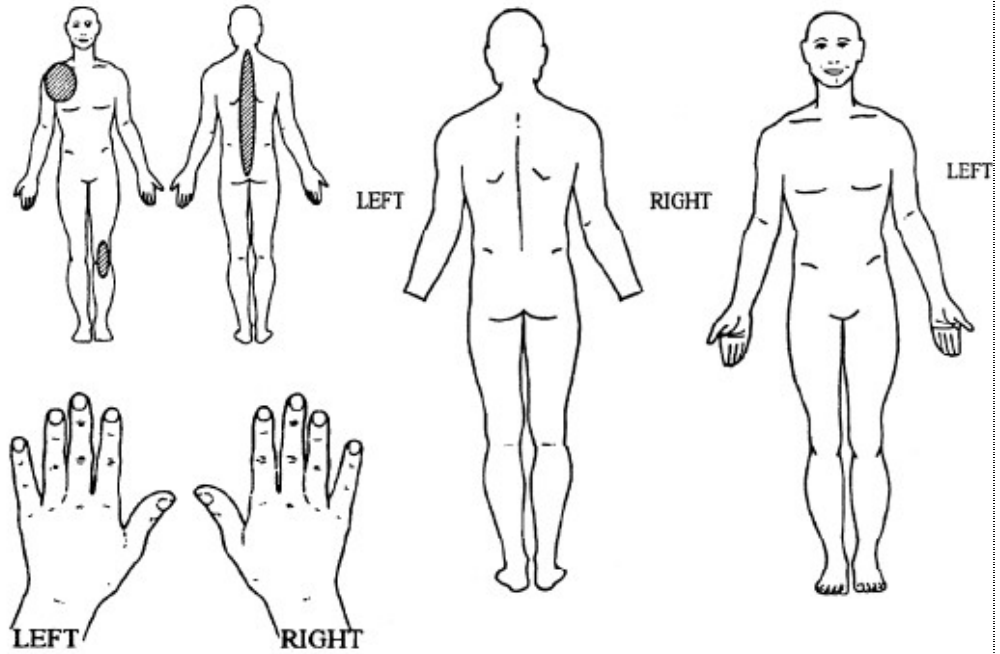
Patient Medical History

First Name:	Last Name:	Birth date:
Age:	Gender: M / F	Referring Physician:
Date symptoms began (if unsure, date when you were first treated):	Describe any injuries/accidents that caused your symptoms:	Do you currently have any open wounds, cuts or abrasions?(if so, where?)
Please list any other treatment for these symptoms and the name of the treatment provider/physician [include surgery and imaging (CT, MRI, X-rays)]:		
Type of treatment/surgery/imaging	Provider	Date (approximate)

Briefly describe your symptoms:

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



	Yes	No	Comments
Do you have metal anywhere in your body (pins/plates, pacemaker, artificial joints, etc)?			
Have you taken steroids or anti-coagulants for an extended period of time?			
Do you smoke?			
Do you exercise regularly?			Type: _____ Frequency: _____
Do your symptoms interfere with your ability to sleep at night?			
How many hours of sleep do you get at night? _____			
Have you used any natural remedies or alternative therapies (chiropractic, magnets, massage, acupuncture, etc)?			
Are you currently receiving/planning to apply for disability?			
Have you had any in-home healthcare in the last 6 months?			Home Health Agency: _____
Do you have a medically related lawsuit pending?			Attorney: _____

Patient Name: _____

Date: _____

Please check any conditions you have currently or have had in the past:

Allergies (list allergen and the type of reaction) :

Joint Swelling/Pain

List joints affected in the last 6 months:

Morning stiffness

Lasting how long?

_____ Minutes _____ Hours

Recent weight gain/loss

Amount: _____

Circle one: Gained Lost

Sensitivity or pain in hands and/or feet

Increased susceptibility to infection

Muscle tenderness/weakness

Shortness of breath/wheezing

Muscle spasm

Tender/swollen glands

Swollen legs or feet

Urinary tract infection

Osteoarthritis

Rheumatoid arthritis

Osteoporosis/Osteopenia

Diabetes

Stomach ulcers

Cancer

Leukemia

Easy bruising

Circulation problems

High blood pressure

Irregular heartbeat

Chest pain

Jaundice

Kidney disease

Stroke

Emphysema

Epilepsy

Asthma

Difficulty breathing at night

Night sweats

Chronic Fatigue Syndrome

Fibromyalgia

General Fatigue

Immune deficiency disorder

Dizziness

Headaches

Nausea/Vomiting

Loss of consciousness

Depression

Anxiety/Panic Attacks

Abnormal hearing

Abnormal vision

Bladder/Bowel incontinence

For women only:

Currently Pregnant
Due Date: ____/____/____

Endometriosis

Other (please explain):

Current Medications

(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium, supplements, etc.)

Name of Medication	Dosage	How long have you taken this medication?	How well does this medication help your symptoms?			
			Very Well	Ok	Not Well	N/A

Additional Comments:

Patient Signature



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Quick Pay Agreement

I, _____ (card holder) authorize El Dorado Physical Therapy to charge my credit card listed below, for charges to include but not limited to co-insurance, deductible, copays, supply charges, finance charges/interest, cancellation/no-show charges and any other balance not covered by insurance.

Using your HSA/HRA is a convenient Interest free option for you.

I prefer to have my card run Weekly Bi-Weekly Monthly, Day of month _____

Card Type: Master Card, Visa, Amex., Health Spending, Discover, Debit circle one _____

Card Number _____ Expiration _____ Code _____

Card Holders Name as it appears on card _____

Card Billing Address _____

Phone number to call if authorization issues occur _____

Unless other arrangements are made, this authorization is to remain in effect until account is paid in full.

Authorized Signature

Date

For office use only

Patient Name _____ Account Number _____ Treating Ofc. _____

Copay _____ Ded _____ Ded. Pymt Plan amount _____

Payment Record

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____