CAMARILLO PHYSICAL THERAPY

4000 CALLE TECATE SUITE 117, CAMARILLO CA 93012

Today's date:			Referring MD:	
PATIENT INFORMATION				
Patient's last name: **First:** **Middle:**			**Birth Date** / /	**Home phone no.:** ( )
Street address:		**Social Security no.:**	**Cell phone no.:** ( )	**Texting Okay?** ❑Yes ❑No
Patient Email:				
P.O. box:	**City:**	**State:**	**ZIP Code:**	
Occupation:	**Employer:**		**Employer phone no.:** ( )	
How did you hear about us? (please choose one) ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Facebook ❑ Yelp ❑ Other				
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Primary Insured	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )	
Please indicate primary insurance:				
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance (if applicable):	**Subscriber's name:**		**Group no.:**	**Policy no.:**
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
INJURY INFORMATION				
Chief Complaint:	**Date of Injury:** / /		**Is this injury work related?** ❑ Yes ❑ No	**Is this injury related to an auto accident?** ❑Yes ❑ No
Current Symptoms: ❑ Pain ❑ Numbness ❑Stiffness ❑Weakness			**Condition:** ❑ New ❑ Acute ❑ Chronic	
Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI, X-Rays, Other?			**Are you allergic to any medications?**	
❑ No ❑ Yes:			❑ No ❑ Yes:	
List any surgeries:				
Are you aware of your Diagnosis? ❑ Yes ❑ No			**Are you aware of your Prognosis?** ❑ Yes ❑ No	

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to ***Camarillo Physical Therapy*** regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Guardian signature *Date*

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices." At any time.

Patient/Guardian signature *Date*

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. AMS Physical Therapy, Inc does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name_____Signature_____Date_____

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CAMARILLO PHYSICAL THERAPY NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices ("Notice") describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your health information. Below is a brief summary of our obligations and your rights, followed by a more detailed description. Please review it carefully.

YOUR RIGHTS You have the right to:

• Receive a copy of your paper or electronic medical record

• Correct your paper or electronic medical record

• Request confidential communication

• Ask us to limit the information we share

• Receive a list of those with whom we've shared your information

• Receive a copy of this privacy notice

• Choose someone to act for you

• File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

•You have some choices in the way that we use and share information as we:

• Tell family and friends about your condition

• Provide disaster relief

OUR USES AND DISCLOSURES

• We may use and share your information as we:

• Treat you

• Run our organization

• Bill for your services

• Help with public health and safety issues

• Conduct research

• Comply with the law

• Address workers' compensation, law enforcement, and other government requests

• Respond to lawsuits and legal actions

OUR RESPONSIBLITIES

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breech occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it,
• We will not use or share your information other than as described here unless you give us permission in writing. If you give us permission, you can change your mind at any time. Let us know in writing if you change your mind.

PRIVACY OFFICER For questions, complaints or for reasons otherwise noted in this Notice, contact Sejal Doshi at 805-383-0470 or via email at camarillophysicaltherapy@gmail.com.
CHANGES TO THE TERMS OF THIS NOTICE We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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Insurance

If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information annually, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please
assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including precertification's, referral and authorization requirements. We, however, will assist you to insure all plan requirements are met.

Payment for services

Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from you insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. We accept cash, checks, MasterCard, VISA, Discover and Care Credit. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability
to pay your debt.

HMO/PPO

It is your responsibility to obtain referrals or pre-authorization as required by your insurance company. Copayments must be paid at the time of your visit.

MEDICARE

We will file your claim with Medicare as a courtesy. If you desire, we will file your secondary insurance for you once we receive payment and the Medicare Explanation of Benefits. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you have any questions on the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

PLEASE UNDERSTAND that we file insurance claims as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. We also are not responsible for any errors in filing your insurance; once again we file claims as a courtesy to you. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as the medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

My signature below constitutes acknowledgement and acceptance of this policy.

_____
Signed

_____
Patient or guarantor Date

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24 Hour Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's scheduling needs and keeps the clinic operating at is most efficient level. Due to our one-on-one, 60-minute treatments, missed appointments are a significant inconvenience to your physical therapist, the clinic and other patients.

This policy is in place out of respect for our therapist AND our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, and leave a 60-minute hole in your therapist's schedule.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 service charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioner(s) to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After two missed or cancelled appointments without the appropriate 24 hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.

Thank you for providing our office and our patients with this courtesy.

I have read, understand, and agree to abide by the policy above:

Print Name: _____

Signature of Patient (or Responsible Party):_____

Date:_____