|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Today’s date:** | | | | | | | | | | | | **Referring MD:** | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | |
| **Patient’s last name:** | | | | **First:** | | | | | **Middle:** | | **Birth Date** | | | **Home phone no.:** | | | |
|  | | | | | | | | | | | **/ /** | | | **( )** | | | |
| **Street address:** | | | | | | **City, State, and Zip Code:** | | | | | | | | **Cell phone no.:** | | | **Texting Okay?** |
|  | | | | | |  | | | | | | | | ( ) | | | ❑Yes ❑No |
| **Patient Email:** | | | | | |
| **Social Security (If VA or Tricare):** | | | | | | |
|  | | | | | | |
| **Occupation:** | | | **Employer:** | | | | | | | | | | | **Emergency Contact:** | | | |
|  | | |  | | | | | | | | | | | ( ) | | | |
| **How did you hear about us? (please choose one)** | | | | | | | |  | | | | | |  | |  | |
| ❑ Family | ❑ Friend | ❑ Facebook | | | ❑ Yelp ❑ Dr. | | | | | ❑ Other | | | |  | | | |
| Injury Information | | | | | | | | | | | | | | | | | |
| **Chief Complaint:** | | | | | | **Date of Injury:** | | | | | | | **Is this injury work related?** | | **Is this injury related to an auto accident?** | | |
|  | | | | | | / / | | | | | | | ❑ Yes ❑ No | | ❑Yes ❑ No | | |
| **Current Symptoms:** ❑ Pain ❑ Numbness ❑Stiffness ❑Weakness | | | | | | | | | | **Condition:** ❑ New ❑ Acute ❑ Chronic | | | | | | | |

**24 Hour Cancellation Policy**

Camarillo Physical Therapy is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at 805-383-0470, 24 hours prior to your scheduled appointment to notify us of any changes or cancellations.** To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday. If prior notification is not given, you will be charged **$50.00** for the missed appointment.

**After 3 consecutive cancellations you will be required to make only same day appointments.**

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

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Responsible Party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. Camarillo Physical Therapy 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.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 ensure 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 your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage. We accept cash, checks, MasterCard, VISA, Discover. 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.

**HMO/PPO**

It is your responsibility to obtain referrals from doctors if your insurance requires it.

**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 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. **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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guarantor Signature Date

**NOTICE OF PRIVACY PRACTICES**

This Notice of Privacy Practices 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](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

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

**ATTENTION**

**All MEDICARE patients please read**

Medicare does **NOT** cover your cost for outpatient therapy (Medicare Part B) if you are receiving home health services of any kind (Medicare Part A).

If you currently receive any of the services mentioned above and choose to continue outpatient therapy with us, you will be responsible for the following out-of-pocket cost:

* Initial Evaluation: $100
* All other visits: $85

This also holds true if you initiate outpatient therapy and then decide later to start home health services of any kind or form while under our out-patient treatment, as Medicare does not cover home services AND outpatient services at the same time. You MUST be discharged by home health BEFORE commencing outpatient physical therapy.

By signing below, I understand that it is my responsibility to inform the office of any changes or addition of home services. Furthermore, I understand that I am responsible for any charges not covered by Medicare as a result of receiving home health care or other therapy services while under the treatment of Camarillo Physical Therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-2019 Pandemic, all patients are required to complete this form prior to being seen at Camarillo Physical Therapy. Your visit is subject to approval upon completion of this form. Effective immediately, only the patient is permitted to be in the clinic during treatment. Caregivers or family must wait outside or in their vehicle. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

Has the patient, caregiver or anyone in your household have travelled outside

the US in the past 2 weeks (14 days)

YES NO

IF YES, WHERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient, caregiver or anyone in your household have travelled outside

of California in the past 2 weeks (14 days)

IF YES, WHERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past 2 weeks (14 days) has the patient, caregiver, or anyone in your

household had contact with any person suspected to have contracted

coronavirus (COVID-19)?

YES NO

Including being tested for COVID-19, & being in self isolation for COVID-19

In the past 2 weeks (14 days) has the patient, caregiver, or anyone in your

household had contact with any person confirmed to have contracted

coronavirus (COVID-19)?

YES NO

Has the patient or caregiver currently been exposed to someone with flu-like

symptoms (cough, shortness of breath or fever)

YES NO

PLEASE CIRCLE IF SYMPTOMS ARE CURRENTLY BEING

EXPERIENCED BY CAREGIVER, PATIENT OR BOTH

IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED

\*Circle any that apply

* COUGHING
* FEVER
* SORE THROAT
* DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING
* MUSCLE ACHES
* STOMACH PAINS
* VOMITING OR DIARRHEA
* PINK EYE/ RED EYES
* RASH
* FATIGUE OR FEELING UNWELL

\*\*Please return this form to the front desk when completed\*\*

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen Saturation: \_\_\_\_\_\_\_\_\_\_\_\_\_