



Rascal Creek Physical Therapy

RCPT account number \_\_\_\_\_

Patient name \_\_\_\_\_ Phone \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Number/Street City Zip

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_ Date of Injury \_\_\_\_\_

Social Security Number \_\_\_\_\_ E-Mail address \_\_\_\_\_

Billing address if different from above \_\_\_\_\_

Responsible Person if different from above \_\_\_\_\_

Private insurance carrier \_\_\_\_\_

Please present your current insurance cards for us to copy.

Name of subscriber \_\_\_\_\_ Birthdate of subscriber \_\_\_\_\_

Secondary insurance carrier \_\_\_\_\_

Workers' Comp carrier \_\_\_\_\_ Claim number \_\_\_\_\_

Medicare number \_\_\_\_\_

Please present your Medicare card for us to copy.

Patient occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ Phone \_\_\_\_\_

Parent or spouse \_\_\_\_\_ Phone \_\_\_\_\_

Referred by Doctor \_\_\_\_\_ Family Doctor \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_  
Name Relationship

Is there someone we can thank for telling you about Rascal Creek PT? \_\_\_\_\_  
Name

**Financial Agreement and Authorization for treatment:**

I authorize treatment of the person named above. I agree to permit all necessary insurance billing for such treatment. In the event that I have a financial obligation for these visits, I agree to pay all charges for me and member of my family shown on the statements, promptly upon presentation thereof, unless credit arrangements are otherwise agreed in advance. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon. All proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

**Agreement:** The above information is warranted to be true.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Responsible person



Rascal Creek Physical Therapy

Name \_\_\_\_\_ Date \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Involved side: Right Left Both

When did symptoms start? \_\_\_\_\_

Did you injure yourself?  Yes  No

How? \_\_\_\_\_

What is your most significant symptom? (Circle most significant symptom)

Pain Swelling Instability Dysfunction Giving Way

Other \_\_\_\_\_

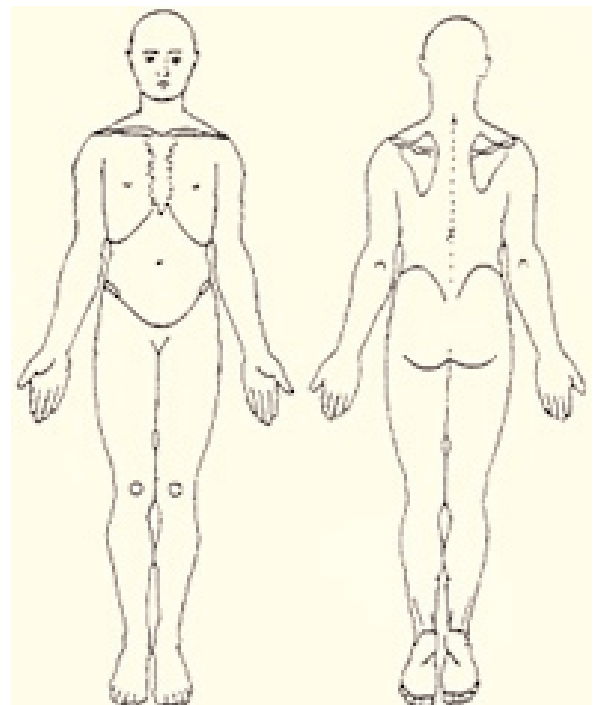
List any previous treatment for this problem:

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

Have you had a previous injury of similar episode?  Yes  No

If yes, when? \_\_\_\_\_

On this body chart, mark the main site of pain with RED ink. If the pain spreads, mark the area where it spreads with BLACK ink.



Thanks for the information. Your therapist will have lots more questions and will be ready to answer your questions during this first visit.

# Rascal Creek Physical Therapy General Health Questionnaire

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

Do you currently have or ever had any of the following conditions or diagnoses?

**Check all that apply.**

## General Medical Conditions

- |  |  |
|--|--|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis)   | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Allergies (seasonal, drug, other)   | <input type="checkbox"/> Anxiety or Panic Disorders  |
| <input type="checkbox"/> Neurological Disease(i.e. MS, Parkinson's)  | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Previous serious accidents  |
| <input type="checkbox"/> Gastrointestinal Disease(ulcer, hernia, kidney, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Bladder, Prostate, or Urination problems                          |
| <input type="checkbox"/> Visual Impairment (such as cataracts, glaucoma, macular degeneration)               | <input type="checkbox"/> Incontinence  |
| <input type="checkbox"/> Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)    | <input type="checkbox"/> Hearing Impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Hepatitis / AIDS  | <input type="checkbox"/> Sleep Dysfunction   |
|  | <input type="checkbox"/> Prosthesis / Implants (metal)                                     |
|  | <input type="checkbox"/> Cancer  |

## Heart Disease

- |   |  |
|---|--|
| <input type="checkbox"/> Congestive heart failure (CHF)       | <input type="checkbox"/> Valvular Disease                    |
| <input type="checkbox"/> High blood Pressure                  | <input type="checkbox"/> Stents                              |
| <input type="checkbox"/> Heart Attack (Myocardial infarction) | <input type="checkbox"/> Arrhythmia                          |
| <input type="checkbox"/> Atherosclerotic Disease (CAD)        | <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) |
| <input type="checkbox"/> Angioplasty                          | <input type="checkbox"/> Pacemaker                           |
| <input type="checkbox"/> Angina                               |  |

## Lung Disease

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Emphysema                             | <input type="checkbox"/> Recent Pneumonia |

## Vascular Disease

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Peripheral Arterial Disease                  | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Chronic Bronchitis                           | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Hypertension                                 |                                       |
| <input type="checkbox"/> Are you taking Blood Pressure Medication     |                                       |
| <input type="checkbox"/> Acquired Respiratory Distress Syndrome(ARDS) |                                       |

**Other / Please describe:**

**List Recent Surgical Procedures:** \_\_\_\_\_

<b><u>Current Medications:</u></b>	<b><u>Reason for taking</u></b>
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\_\_\_\_\_

<b><u>Signature:</u></b>	<b><u>Date:</u></b>
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Rascal Creek Physical Therapy, a P.C.  
3327 M Street, Suite A  
Merced, CA 95348

Pt: \_\_\_\_\_  
SS# or DOB \_\_\_\_\_

## **PAYMENT POLICY**

1. The patient is fully responsible for payment of all charges regardless of insurance or lawsuit determination. Payment by cash, check, Mastercard, or Visa is acceptable. All charges over 90 days are to be paid in full by the patient unless prior arrangements are made.
2. Health insurance patients will have a bill sent directly to their primary insurance carrier. The patient is responsible for supplying us with any additional forms required. We must also have a signed Assignment of Benefits on file so payments are made directly to Rascal Creek Physical Therapy. We will make every attempt to determine patient's liability in advance but ultimately, payment in full is the patient's responsibility. Any co-payment required by insurance will be billed to the patient weekly and is due upon receipt. Any overpayment on the account when all transactions are completed will be refunded to the patient and the appropriate insurance company.
3. We are an approved Medicare provider and accept assignment. Secondary insurance, if applicable, will be billed as a courtesy. Make sure you understand Medicare limitations and restrictions when beginning treatment. We do not have all the answers but we will help as much as we can.
4. Personal injury cases are handled in the same manner as our Health Insurance cases. We will bill insurance upon request. If the claim is disputed or denied, the patient is fully responsible for the balance on the account. An attorney lien will NOT be accepted on these cases; however, if another insurance is available, we will bill at time of service with information provided.
5. Workers' Compensation cases will be billed directly to the employer's compensation carrier. Workers' Comp patients are expected to provide the correct name, address and adjuster of carrier, claim number, employer and address, date of injury and attorney if applicable at time of first visit. In the event of a denied claim the patient may be held responsible for any unpaid charges.
6. Secondary insurance carriers and Medicare supplemental insurance carriers will be billed upon receipt of explanation of benefits. Overpayment from dual coverage will be refunded to the appropriate insurance carrier. This is a courtesy billing and the patient will be responsible for any co-payment.
7. Rebilling charges of up to 1.5% per month may be added to delinquent accounts with no payment received for 30 days. Keep account current or make prior arrangements to avoid additional charges. Overdue accounts will be turned over for collections if necessary.
8. We appreciate your cooperation and are here to help you. If you have any questions, don't hesitate to ask now.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Rascal Creek Physical Therapy **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. This is the patient's copy of our policy.

Rascal Creek Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Rascal Creek Physical Therapy 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, Rascal Creek Physical Therapy 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.

Rascal Creek Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Rascal Creek Physical Therapy'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.

Rascal Creek Physical Therapy may change its policy at any time. When changes are made, a new Notice of 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 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. Rascal Creek Physical Therapy 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 Rascal Creek Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Rascal Creek Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Rascal Creek Physical Therapy  
Tony Hernandez, DPT  
3327 M St. Suite A, Merced, CA 95340  
Telephone: (209) 722-1030

**Rascal Creek Physical Therapy**  
**PATIENT INFORMATION ACKNOWLEDGEMENT FORM**  
**CLINIC COPY**

I have read and fully understand Rascal Creek Physical Therapy's Notice of Information Practices. I understand that Rascal Creek Physical Therapy may use or disclose my personal health information for the purposes 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 Rascal Creek Physical Therapy 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 my personal health information for purposes as noted in Rascal Creek Physical Therapy'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 Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date