



Rascal Creek Physical Therapy

RCPT Account Number _____

Patient Name _____ Home Phone _____
Last First MI

Address _____ Cell Phone # _____
Number/Street City Zip

Can we leave a message on home phone? Yes No

Cell Phone? Yes No Can we use text messaging? Yes No

Birthdate _____ Age _____ Sex _____ Marital Status _____ Date of Injury _____

Social Security Number _____ E-Mail Address _____

Can we notify you about appointments via e-mail? Yes No

Private Insurance Carrier _____
Please present your current insurance cards for us to copy.

Name of Subscriber _____ Birthdate of Subscriber _____

Secondary Insurance Carrier _____

Name of Subscriber _____ Birthdate of Subscriber _____

Workers' Comp Carrier _____ Claim Number _____

Patient Occupation _____ Employer _____

Employer's Address _____ Phone _____

Referred by Doctor _____ Family Doctor _____

Emergency Contact _____ Phone _____
Name Relationship

May we discuss your medical condition or billing with another person? Yes No

Name _____ Phone _____

Is there someone we can thank for telling you about Rascal Creek PT? _____

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 members of my family shown on the statements, promptly upon presentation thereof, unless credit arrangements are otherwise agreed upon 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 General Health Questionnaire

Name: _____

Do you currently have or ever had any of the following conditions or diagnoses?
Check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Other _____ |

Have you had an injury as result of a fall in the past year? yes no

Have you had two or more falls in the last year? yes no

How many alcohol drinks per week? _____ drink per occasion? _____

Ht _____ Wt _____ Involved side _____

When did your symptoms start? _____

How did you injury yourself? _____

List recent surgeries: _____

Current Medications:	Dosage	Frequency	Reason for Taking
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Signature: _____ Date: _____

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

I have read and fully understand the Rascal Creek Physical Therapy (hereafter RCPT) Notice of Information Practices. I understand that RCPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and for any administrative operations related to treatment or payment. In addition, RCPT has my permission to use my demographic information for purposes of announcements, statistics, marketing surveys and birthday cards. 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 RCPT. I understand that RCPT will consider requests for restrictions 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 noted in the RCPT Notice of Information Practices. I consent to the use of my demographic information for purpose as noted. I understand that I retain the right to revoke this consent by notifying RCPT in writing at any time.

Patient Name

Signature

Date