PATIENT INFORMATION

Please Print and Fill Out Completely

Patient Name: ______________________________________ Preferred Language: ______________

Married Single Widowed Divorced Separated Birthday: ______________________

Home Address: ______________________________________ Social Sec No: ________________

City: ____________________________ Zip: _____________ Home Phone: ___________________

Patient Employed by: _________________________________ E-mail: ______________________

Business Address: ___________________________________ Business Phone: ________________

Occupation: ____ City: _________________________

Emergency Contact: __________________________________ Doctor: _______________________

Contact Phone#: _____________________________________ Doctor Phone No: ________________

Referral Source: [ ] Physician [ ] Yellow Pages [ ] Friend [ ] Newspaper [ ] Insurance Co. [ ] Other

Is this a work related injury? [ ]YES [ ] NO If accident/injury, is litigation involved? [ ]YES [ ] NO

IF ANOTHER PARTY, IN ADDITION TO PATIENT, WILL ASSUME RESPONSIBILITY FOR PAYMENT OF PATIENT'S BILL PLEASE COMPLETE THE FOLLOWING:

Please Note: Patient is primarily responsible for his/her bill.

Responsible Party: _________________________________ Phone: ___________________

Address: _______________________________________ City: ___________ Zip: ______

Employer: ______________________________________ Business Phone: ____________

IF YOU HAVE MEDICAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

Name of Company: ____

Certificate or Member I.D. Number: _______________________ Group Number: ____________

Subscriber/Insured: __________________________________ Date of Birth: _____________

Medicare Number: ___________________________________ Medi-Cal Number: __________

Remarks: ____

IMPORTANT **-** *We call on your insurance benefits as a courtesy. Verification of benefits is not a guarantee of payment by your insurance company. We strongly encourage our patients to call and confirm their benefits. I understand I am responsible by law for the timely payment of my account. If I fail to pay my balance in a timely manner, I am aware my account will be sent to collections, where it may accumulate interest.* ***Initials***_________

AUTHORIZE INSURANCE TO PAY

I hereby authorize ______________________________________ Insurance Company to pay by check made payable to and mailed directly to:

DYNAMIC PHYSICAL & HAND THERAPY, INC.
500 PASEO CAMARILLO SUITE 105
CAMARILLO, CALIFORNIA 93010

for the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward charges for Professional Services Rendered. This payment will not exceed my indebtedness to the aforementioned assignee and have agreed to pay, in current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient Signature: ____________________________ **Date**:________________

Patient Representative:______________________Relationship:_____________**Date**:________________

(If not patient, indicate parent, guardian or other)

Dynamic PHYSICAL & HAND THERAPY, INC.

PATIENT HISTORY FORM

Name: ____________________________________ Sex: ______ Date of Birth: ___ / ___ / ___

1. Have you ever had any problems with the following?

	YES	NO		YES	NO
High Blood Pressure	___	___	Diabetes	___	___
Heart/Lung	___	___	Arthritis	___	___
Circulation	___	___	Cancer	___	___
Seizures	___	___	Vision/Hearing	___	___
Dizziness/Nausea	___	___	Do You Have a Pacemaker?	___	___

2. What brings you to Therapy Today:____

3. If result of an accident or injury, when did it occur? ___ / ___ / ___

If not, give onset: ___ / ___ / ___ & when it was diagnosed: ___ / ___ / ___

4. Did you have surgery for this condition? [ ] YES [ ] NO

If Yes, give dates & type(s) and Surgeon:____

____

5. Since the date of injury your symptoms have: [ ] Improved [ ] Stayed the same [ ] Worse

6. Do you have any metal implants (other than teeth)? [ ] YES [ ] NO ____________________________

7. Are you pregnant? [ ] YES [ ] NO

8. Current medications (**Name, Frequency & Reason**):_____________________________________

____

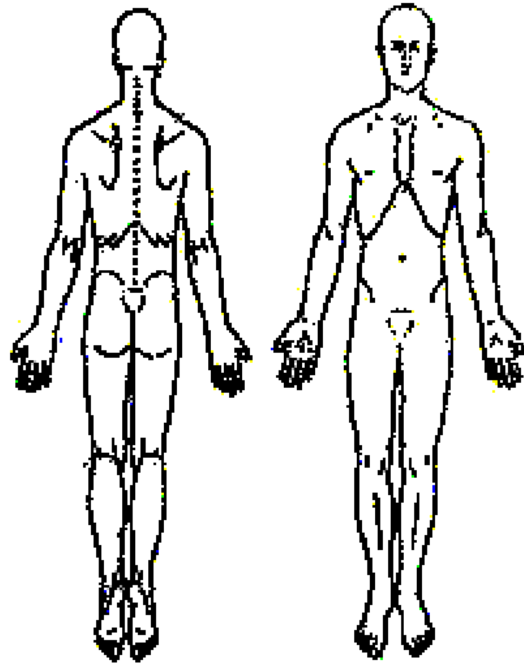
9. Have any tests been taken for your **current** problem? X-RAYS, MRI's, EMG's, NCV's, CAT SCANS, BONE SCANS, ARTHO or ANGIOGRAMS, STRESS TEST, EKG's or OTHERS. If **Yes**, when & who recommended them? ____________________________________

____

10. Current problem:________________________

Please note on the body drawing to the right:

1) Where the pain is
2) Where the pain travels to



11. What makes your pain worse:

____

____

12. Have you ever had physical, social or vocational rehabilitation/clinical psychology treatments?

[ ] YES [ ] NO If Yes, indicate where, when & for what problems:____

____

13. MEDICARE PATIENTS: Have you in the past 3 months or are you currently receiving any type of services through a *home health agency*, i.e., any person coming to you home to provide any type of services? [ ] YES [ ] NO

(PLEASE BE ADVISED THAT MEDICARE WILL NOT PAY OUTPATIENT PT & HOME HEALTH SERVICES TOGETHER)

Patient Signature: ______________________________________**Date**:____________________

Patient Representative:_________________________Relationship:____________________Date:__________

(If not patient, indicate parent, guardian or other)

500 Paseo Camarillo Suite 105, Camarillo, CA 93010
(805) 987-6851

AGREEMENT TO PAY

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE AND LIABLE FOR REPAYMENT OF ALL CHARGES ASSESSED FOR PROFESSIONAL SERVICES RENDERED ON MY BEHALF AND HEREBY EXPRESSLY AGREE TO PAY ANY AND ALL SUMS DUE UPON DEMAND.

I understand and expressly agree that my responsibility and liability is not, in any way, diminished, mitigated, eliminated, released, excused or affected by the fact that another party has agreed to assume responsibility for my bill and/or by the fact that I may have medical or other insurance which may provide coverage for the medical services being provided on my behalf.

I understand that, as a matter of accommodation and convenience to me only, billings may be submitted to other parties who may have agreed to assume responsibility for my bill as well as to my insurance company or companies. I expressly agree to fully cooperate with Dynamic Physical & Hand Therapy, Inc. in the processing of insurance claim forms. In the event that my insurance company may forward payment to me directly, instead of to Dynamic Physical & Hand Therapy, Inc., I expressly agree to immediately deliver such payment to Dynamic Physical and Hand Therapy, Inc.

I understand and expressly agree that, if my insurance does not provide for and pay 100% of the billings submitted by Dynamic Physical & Hand Therapy, Inc., I will pay any deductible portion of such billing at the time services are provided. Additionally, that portion or percentage of the charges for medical services which is not covered by my insurance will be paid by me at the time such medical services are provided on my behalf.

I understand and expressly agree that, if I or someone acting on my behalf does not provide Dynamic Physical & Hand Therapy, Inc. with **at least 24 hours advance notice** of any cancelled treatments that I will be responsible for the **$75.00 cancellation/no show fee**, and that if I suspend or terminate my care and treatment, the fees for professional services rendered to me will be immediately due and payable.

I understand and expressly agree that an interest charge equal to 1.5% per month will be added to my bill for all charges which have not been paid in full within sixty (60) days after billing to either myself, another party who has agreed to assume responsibility for payment of my bill, or to my insurance company.

I understand and expressly agree that if it becomes necessary to commence legal action for the collection of any outstanding charges to my account, I will be responsible for and agree to pay any and all attorney fees and costs actually incurred by Dynamic Physical & Hand Therapy, Inc., in addition to the outstanding balance due on my account.

Patient Signature: ______________________________ Date:______________

Patient Representative:________________________Relationship:______________Date:_____________

(If not patient, indicate parent, guardian or other)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

We will use your protected health information (PHI) for the purpose of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health care operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Our practice may use your PHI to send you an appointment reminder and to inform you of our other health-related products and services.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurance that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release PHI about you when it is determined to be necessary by the appropriate military authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communication

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact
If you would like more information about our privacy practices or to file a complaint you may contact:

Daniel Johnston
Privacy Office / President
500 Paseo Camarillo Suite #105
Camarillo, CA 93010
(805) 987-6851

Effective Date: April 14, 2003

Please sign below to affirm that you have received a copy of our Privacy Practices Policy.

Patient Signature: ______________________________ Date:______________

Patient Representative:________________________Relationship:______________Date:_____________

(If not patient, indicate parent, guardian or other)