



Office Policies

All patients must recognize that they are responsible for the charges incurred for physical therapy. We will attempt to verify what your insurance benefits are. However, quotation of benefits from your insurance company does not guarantee payment. We will submit billing to your insurance company free of charge. In the event that your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment.

Missed appointments are a loss for everyone. Cancellations without adequate notice cannot be filled and take valuable time from other patients, thus they are subject to a \$20 no show fee. Therefore, we require that you notify us one day in advance if you are unable to attend a scheduled appointment. If you are 15 minutes late or greater, the therapist will have the option of seeing you or rescheduling. Checks that are returned for any reason are subject to a \$10 service fee.

Authorization and Assignment of Benefits:

I hereby authorize and direct you, my insurance company, to pay directly to Cameron Park Physical Therapy Center, Inc. such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company, obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the amounts due this office for their services. I further understand and agree that this assignment and authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, billing service, adjuster, or attorney to facilitate collection under this assignment and authorization.

MEDICARE PATIENTS: *We bill our standard fees to Medicare, they pay 80% of their allowable fees, and the difference is billed to your secondary insurance. If you do not have a secondary insurance or your secondary insurance denies payment, you will receive a statement following the receipt of Medicare's allotment. Unless other arrangements are made, you will be responsible for the remaining 20% of the Medicare allowable rate.*

Other arrangements _____

Date: _____

Signature: _____

Print Name: _____



New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Cameron Park Physical Therapy Center, Inc. (CPPT, Inc) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided, (see brochure at front desk), with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. If I have any further questions in regards to the Privacy Practices I can contact the privacy officer.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that CPPT, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CPPT, Inc reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CPPT, Inc change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of CPPT, Inc treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax.

I fully understand and accept the terms of this consent

 Patients Signature

 Date



**CAMERON PARK
PHYSICAL
THERAPY
CENTER**

"The Thought Behind Quality Physical Rehabilitation"

Past Medical History Form

Name: _____ Date _____

Are you presently working? Yes No

Check which one applies to your condition:

- Motor vehicle accident Work-Related injury Injury related to falling
 Recurrence of previous injury Injury related to lifting Cause unknown
 Athletic/Recreational injury Other:

Have you ever had these symptoms before? Yes No

Have you had a related surgery? Yes No

Do you have any of the following:

- | | | | | | |
|-------------------------------|-----|----|---------------------|-----|----|
| Pacemaker | Yes | No | Unusual Headache | Yes | No |
| Chest Pain/Angina | Yes | No | Osteoporosis | Yes | No |
| Heart Disease/Attack | Yes | No | Hernia | Yes | No |
| High Blood Pressure | Yes | No | Seizures | Yes | No |
| Cancer/Tumor | Yes | No | Metal Implants | Yes | No |
| Kidney Problems | Yes | No | Dizziness/Fainting | Yes | No |
| Stroke | Yes | No | Fracture | Yes | No |
| Bowel/Bladder Abnormalities | Yes | No | Surgeries | Yes | No |
| Pregnancy | Yes | No | Skin Abnormalities | Yes | No |
| Asthma/Breathing Difficulties | Yes | No | Nausea/Vomiting | Yes | No |
| Liver/Gallbladder Problems | Yes | No | ringing in ears | Yes | No |
| Hypoglycemia /Diabetes | Yes | No | Rheumatic Arthritis | Yes | No |
| Osteoarthritis/Rheumatoid | Yes | No | Smoking | Yes | No |
| Other _____ | Yes | No | | | |

If you answered **Yes** to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

Do you have any allergies? Yes No

If yes, please list your allergies: _____

Are you presently taking any medications? Yes No

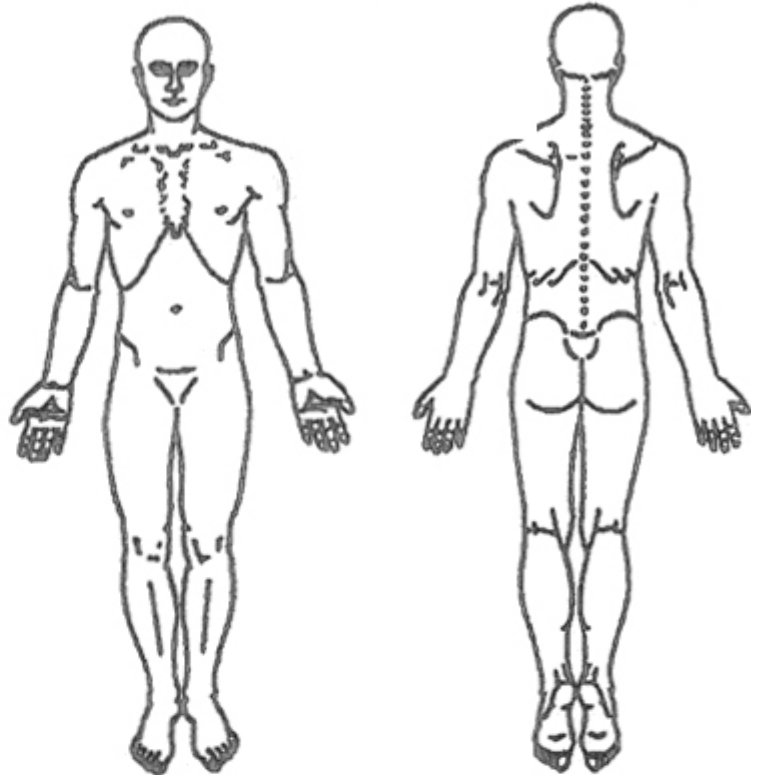
If yes, please list what medications and for what condition:

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- | | | |
|---|-----------------------------|--------------------------------|
| Ache
MMM
M | Burning

-- | Numbness
OOOO
OOO |
| Pins and Needles
□□□□□□□□
□□□□□□□□ | Stabbing
///// | Other
xxxx
xxx |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments: _____