Cotati-Rohnert Park Physical Therapy Patient Information Sheet

Patient Name _____ **(M / F) DOB:** _____ **Age:** _____

Home Address_____ City_____ State:_____ Zip _____

Home PH#: _____ Cell/Work/Other: _____

Email Address: _____

Referring Provider: _____ **SSN#:** _____

Married **Divorced** **Single** **Minor/Child** **Widowed** **Separated**

✓ **Have you had PT services this year**? _____

✓ **Are you currently receiving <u>ANY</u> home health services**? _____

Primary Insurance Company Name: _____

ID / Subscriber Number #: _____ Group#: _____

Name of **Responsible Party**, if different than Patient: _____

DOB: _____ SSN#: _____ Employer: _____

Private Health Insurance:

It is ***your*** responsibility to know the benefits and limitations of your particular insurance policy. For insurance companies that we do not contract with the services rendered with be your responsibility at the Usual & Customary rates for this area. **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

****Twenty-four hours notification** is requested when canceling and appointment. Thank you!

I **authorize** the release of **any medical** or **other** information necessary to process claims on my behalf. I **<u>agree</u>** to be **<u>fully</u> responsible** for all lawful debts incurred by myself for services received from **Cotati-Rohnert Park Physical Therapy,** whether covered by insurance or not.

I have read, understand, and **agree** to the above stated financial policies. I **consent** to therapeutic treatment and services rendered, which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

<u>Signature:</u> _____ <u>Date:</u> _____

Cotati-Rohnert Park Physical Therapy

Cancellation Policy

We require that patients call and give us 24-48 hours advance notice that you will be canceling your appointment. We do understand that emergencies happen.

Due to the number of increase no shows and last minutes cancellations, as of **Jan 1, 2018,** we have had to implement a change to our policy.

There will be a $50 **charge** to patients who no show, cancel at the last minute (i.e., not giving us **a 24-hour notice**). This will need to be paid prior to your next appointment. If we need to bill this to you, **the fee will double** ($100). **No Exceptions!**

Please arrive on time to your scheduled appointment. **If you arrive more than ten** (10) **minutes late,** this will hinder your treatment and we cannot do justice for your recovery. If it appears that this has been done more than 2 times, you will be placed on a **same day appointment list.**

We value our therapist time and the time for our patients. If you are unable to keep your appointment we would appreciate enough notice so that we are able to get someone else into your slot.

We have the option to add you to our reminder list. Text, voice call or e-mail. We will gladly add it to your e-chart.

Please sign, print and date below so we know you've acknowledged our policy.

Print: _____

Sign: _____

Date: _____

Cotati-Rohnert Park Physical Therapy Inc.

Consent for Treatment:

"I understand that I have been referred for rehabilitative treatment and care to Cotati-Rohnert Park Physical Therapy Inc. (CRPT). I understand that I have the right to ask and have questions answered prior to receiving my treatments including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have CRPT provide treatment and care as prescribed."

"I consent to and authorize CRPT to administer all treatments and services that may be considered advisable in the Judgment of any physician and/or therapist in accordance with CRPT policy."

Financial Responsibility:

"I, the undersigned, _____ . accept full responsibility for charges incurred for the health care)erv1cc, rendered. Including, but not limited to, any amount not paid by insurance or other third party payer."

"I, _____ accept responsibility for all co-payments, deductibles, co-insurance and/or non-covered services regardless of amount paid by insurance or third parter payer. I understand that co-payments are due at the time of service."

"I, _____ understand that Insurance payments are my responsibility. Although, it is billed as a courtesy, I am ultimately responsible to see that my insurance pays correctly and in a timely manner."

It is understood and agreed that charges not paid in a timely manner may be placed with a collection agency or attorney. Should payment not be received, I/we will be responsible for all attorney fees, court cost, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue collection of the balance owing, which ma be as much as 50% of the principlal balance. I/We, further agree to pay interest at the rate of 1½% per month (18% APR) pre and post judgment. A service charge may also be assessed on all returned checks.

Medicare/Medicaid Patient's Certification:

I certify that the information given by me in applying for payment is correct. I authorize any information needed for the processing of a claim to be released. I request that payment of authorized charges be made, on my behalf, directly to Cotati-Rohnert Park Physical Therapy Inc.

Signature: _____ **Date:** _____

Cotati-Rohnert Park Physical Therapy Inc
7840 Old Redwood Hwy
Cotati, CA 94931
(707)795-1636

To our patients: this notice describes how health information about you may be used and how you can get access to your health information. This is required by the Privacy Regulations stated in the Health Insurance **Portability and Accountability Act of 1996 (HIPPA)**.

Our commitment to your privacy. Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of health information:

1. To public health authorities that are authorized by law to collect information.
2. Lawsuits and other proceedings in response to a court or administrative order.
3. Required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of others. We will only disclose to a person/agency to help prevent that threat.
5. If you **are a** member of a US foreign military force (vets as well) and if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials ifyou are an inmate or under their custody.
8. For Worker's Compensation and similar programs.

Your rights regarding your health information:

1. **Communications:** You can request that Iden Warnock PT communicate with you about your health in a particular manner or at a certain location. You may want us to contact you at home only.
2. You can request a restriction in our use or disclosure of your health information for treatment, **payment,** or **health care operations.** You have the right to request that we restrict our disclosure to only certain individuals such as family members. **We are not required to agree:** However if we do, we arc bound by our agreement except when required by law, in emergencies, or when their information is necessary to treat you.
3. You have the right to inspect and obtain a copy ofthe health information such as medical records and billing records. You must submit your request in writing to: Iden Warnock PT. Cotati-Rohnert Park Physical Therapy Inc. Attention: Medical Records at the above address.
4. You may amend your health information if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to: Cotati-Rohnert Park Physical Therapy Inc. Attention: Office Manager at the above address.
5. **Right to a copy of this Notice: You are entitled to receive a copy of our Notice of Privacy Practices. You may ask us for a copy of the Notice at anytime by contacting our front office.**
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Dept. ofHealth and Human Services. To file a complaint with our practice, contact our office manager. You will not be penalized.
7. **Our practice will obtain your written authorization for uses/disclosures that arc not identified by this notice or permitted by applicable law.**

If you have any questions regarding this notice or our health information privac) policies, don't hesitate to contact us.

I hereby acknowledge that I have reviewed this Privacy Notice for Cotati-Rohnert Park Physical Therapy Inc.

Date: _____

Print Name: _____ Signature: _____