COAST PHYSICAL THERAPY

PATIENT INFORMATION

Please present your insurance card(s) for copying.

Patient Name:	**Sex:**	**Date of Birth:**	**Age:**
Social Security Number:	**Employment Status:** Emp Unemp Retired Student	**Marital Status:** Single Married Other	
Address:	**City**		
State	**Zip Code**	**Home Phone:**	**Work Phone:**
Employer:	**Referring MD:**		
Attorney:	**Attorney Address:**	**Attorney Phone:**	
Financial Party:(if other than patient)	**Relationship:**	**Social Security Number:**	**Date of Birth:**
Home Phone:	**Work Phone:**	**Employer:**	
Emergency Contact:	**Relationship:**	**Home Phone:**	
Address:		**Work Phone:**	
Current Injury:	**Date of Onset:**		

Medical History: Have had any of the following: (circle yes or no)

High Blood Pressure	**yes no**	**Pregnancy**	**yes no**	**Metal Implants**	**yes no**
Heart Attack	**yes no**	**Allergies**	**yes no**	**Previous Surgery**	**yes no**
Heart Disease	**yes no**	**Hernia**	**yes no**	**Fever**	**yes no**
Pacemaker	**yes no**	**Seizures**	**yes no**	**Cancer**	**yes no**
Headaches	**yes no**	**Sensitive to heat or ice**	**yes no**	**Nervous Disorders**	**yes no**
Kidney Problems	**yes no**	**Night Pain**	**yes no**	**Diabetes**	**yes no**

Please list current medications:

Please give a brief explanation and dates for any area marked yes:

The above information is correct to the best of my knowledge. In signing below, I agree to be treated by the staff of Coast Physical Therapy. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Coast Physical Therapy. I authorize payment of medical benefits directly to Coast Physical Therapy. I understand that I am financially responsible to Coast Physical Therapy for all unpaid balances.

Signed: _____ Date: _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL IN FORMATION ABOUT YOU MAY B E USED OR DISCLOSED HOW YOU C AN GET ACCE SS TO INFORMATION. PLEASE REVIE W IT CAREFULLY.

COAST PHYSICAL THERAPY'S LEGAL DUTY

Coast 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

Coast Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administ rative activities and evaluating the quality of care that we provide. For example, we 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.

Coast Physical Therapy m ay also use or disclose your personal health in formation without prior authorization for e mergencies, research studies, audi ting purposes, and public heath/statistical purposes. W e also provide inform ation when required by law. In any other situation, our' policy is to obtain your written authorization before disclosing yo ur personal health inform ation. If you provide us with a written authorization to release your inform ation for any reason, you m ay later re voke that authorization to stop future disclosures at any time.

Coast Physical Therapy m ay change its policy at any time. W hen changes are m ade, a new Notice of Information Practices will be pos ted in the waitin g room and patient exam areas and will be p rovided 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 pe rsonal health information at any tim e. You have the right to requ est that we correct any inaccurate or inco mplete information in your reco rds. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatm ent, paym ent or other related adm inistrative purposes. You m ay also re quest in writing that we not use or disclose your personal health inform ation for treatm ent, pay ment and adm inistrative purposes except when specifically authorized by you, when re quired by law or in em ergency circum stances. Coast 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 we m ay have violated your privacy ri ghts or if you disagree with any decisions we have m ade regarding access or disclo sure of your personal health inform ation, please contact our Privacy Officer at the address listed below. You may also send a w ritten complaint to the US Department of Health and Human Services. For further information on our health inform ation practices or if you ha ve a complaint, please contact the following person:

Coast Physical Therapy
Attn: Kevin Vaughn, Privacy Officer

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Coast Physical Therapy's Notice of Information Practices. I understand that Coast 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 Coast 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 Coast Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Signature: Date:

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

As required by Health Information Portability and Accountability Act (HIPAA) OF 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone
I want you to contact me by telephone at: _____
_____ **Do** _____**Do not** leave messages on my answering machine
_____**Do** _____**Do not** leave messages with any other person

Please indicate name, if any, of individual(s) approved to take above messages:
_____

Diagnosis & Treatment
I, _____ **Do** _____ **Do not** want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):
_____

Mail
I want you to contact me at the following address: _____ Home Other: _____

Signed: _____ Date: _____

Print name: _____

If not signed by the patient, please indicate relationship:
_____ Parent or guardian of minor patient
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of patient: _____

OFFICE PAYMENT POLICY - COAST PHYSICAL THERAPY

It is the policy of Coast Physical Therapy that payment is due and to be made at the time of service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 30, 45 or 60 minutes long. Charges range from $25 to $40 per 15-minute increments, depending upon the type of treatment being performed. If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manger before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a co-pay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and co-pays are due at the time of service. We will bill you for coinsurance or other payment due after we have been paid by your insurance or notified of their denial for payment.

_____ 2. HMO Insurance: Authorization from your insurance must be obtained prior to treatment. Any co-pay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

_____ 3. MEDICARE: Coast Physical Therapy is a certified Medicare provider. Medicare has an annual deductible of $100.00 for PT and Speech and an annual benefit cap of $1740 . Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

_____ 4. NO INSURANCE: If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____ 5. OTHER: Please list the other type of payment: _____

_____ 6. WORKER'S COMPENSATION CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

_____ 7. THIRD PARTY PAYERS AND AUTO LIENS: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. You are responsible for payment of all service provided. Please be sure to contact this office when your case is settled to ensure your account has been paid. ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS: Please sign a release of information authorizing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid. I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____

COAST PHYSICAL THERAPY CANCELLATION POLICY

SHOULD ANY PATIENT NOT BE ABLE TO MAKE A PREVIOUSLY SCHEDULED APPOINTMENT, A 24-HOUR NOTICE OF CANCELLATION MUST BE GIVEN BY PHONE OR IN PERSON TO THE OFFICE MANAGER. IF THERE IS NOT NOTICE OF CANCELLATION 24 HOURS BEFORE THE SCHEDULED APPOINTMENT, A $25 CHARGE WILL BE BILLED DIRECTLY TO THE PATIENT FOR EACH CANCELLATION. WE AT COAST PHYSICAL THERAPY WANT TO PROVIDE THE BEST POSSIBLE CARE FOR OUR PATIENTS AND ATTENDING YOUR SCHEDULED APPOINTMENTS IS THE NECESSARY PART OF THE TREATMENT PROCESS. IF YOU HAVE ANY FURTHER QUESTIONS PLEASE DO NOT HESITATE TO ASK THE OFFICE MANAGER OR YOUR THERAPIST.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ, UNDERSTOOD, AND AGREE WITH OUR CANCELLATION POLICY.

SIGNATURE _____ DATE _____

Coast Physical Therapy Referral Information

To improve our customer service, cut down on the amount of paper used, and improve our quality of care, we would appreciate it if you would answer a couple of questions.

1. Please provide us with your email address. You will receive contact information, a newsletter, and information regarding your bill. **(Private health information is not sent via the Internet.)**

First Name: _____ Last Name: _____

Email Address: _____

2. How did you find out about Coast Physical Therapy?
(Please check all that apply)

- ☐ My doctor referred me to your clinic.
- ☐ I found out about your clinic from a friend.
- ☐ I was a previous patient.
- ☐ I heard about your services from one of your physical therapists.
- ☐ I learned of your services from your email newsletter.
- ☐ I learned of your clinics and services from the Internet.
- ☐ Other _____
- ☐ Don't send me the newsletter

Best Regards,

The Staff at Coast Physical Therapy