CHICO PHYSICAL THERAPY ASSOCIATES, INC

PATIENT INFORMATION

Referred By: _____ MD/DO/PAC/FNP Date: _____

Patient Name: _____ Male / Female (Circle)
LAST FIRST INITIAL

Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Phone #: _____ Birth Date: _____ Age: _____ Social Sec #: _____

Employed by: _____ Work Phone #: _____ Cell #: _____

Marital Status: S M W D Sep (Circle) E-mail Address: _____

Spouse or Parent Name: _____ Employed by: _____

Work Phone # _____ Cell #: _____

Reason for Therapy: _____ Is this a Work Related Injury: Yes No (Circle)

Date of Onset/Injury/Surgery: _____

Any Previous Outpatient Physical Therapy in Current Year? Yes No (Circle) If Yes, Where and When _____

_____

Contact Name & Number In Case of Emergency: _____

Name of Person Responsible for Bill: _____

Primary Insurance: _____ Secondary Insurance _____

_____

Do you now have/or had any of the following:

Diabetes	Yes	No	Previous orthopedic surgery	Yes	No
High Blood Pressure	Yes	No	Metal Implants	Yes	No
Heart Disease	Yes	No	Please explain: _____		
Pacemaker	Yes	No			
			Are you Pregnant	Yes	No

I authorize Chico Physical Therapy Associates, Inc and its therapist in charge of my care to perform all necessary and advisable medical procedures for diagnosis and treatment. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement. I also understand that I have the right to decline or refuse any proposed medical procedures or treatment.

I authorize Chico Physical Therapy Associates, Inc to disclose my medical records to my insurance company. I understand that it is my responsibility to contact my insurance company regarding questions I have on my benefits, including visit or dollar limits.

I assign to and approve direct payment to Chico Physical Therapy Associates, Inc of any insurance benefits. I understand that I am financially responsible to Chico Physical Therapy Associates, Inc for co-payments, co-insurance, deductibles, and any services non-payable under my plan.

Signed: _____ Relationship: _____

Chico 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.

Chico Physical Therapy's LEGAL DUTY

Chico 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 descried herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Chico 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, Chico 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.

Chico 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, Chico 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.

Chico 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. Chico 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 Chico 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 Heath and Human Services. For further information on Chico Physical Therapy's health information practices or if you have a compliant, please contact the following person:

CHICO PHYSICAL THERAPY
Michael Hernandez, PT. Steven Snider, MPT
260 Cohasset Road Suite 185, Chico, CA 95926
Telephone: (530) 891-1366 **Fax: (530) 891-0950**
Effective April 14, 2003

Chico Physical Therapy

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Chico Physical Therapy's Notice of Information Practices. I understand that Chico Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, and evaluating the quality of services provided. 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 Chico Physical Therapy 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 as noted in Chico Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Cancellation/Missed Appointment Policy

Chico Physical Therapy is committed to providing quality medical care in a timely manner. In order to do so, we have implemented an appointment reschedule/cancellation/no show policy. This policy enables us to better utilize available appointments for our patients.

Cancellation/Rescheduling of Appointments – Please call our office promptly if you are unable to attend an appointment. We require at least 24 hours notice, so that your appointment time can be reallocated to someone else. Please call us at (530) 891-1366 or (530) 893-1366 to notify us of any changes or cancellations. To cancel or reschedule a Monday appointment, please call our office by 2:00 p.m. on Friday.

- The first time a patient fails to attend a scheduled appointment and/or cancel in a timely manner will be given a warning.
- The second time a patients fails to attend a scheduled apointment and/or cancel in a timely manner will result in a $25 "no show" patient charge.
- The third time a patient fails to attend a scheduled appointment and/or cancel in a timely manner within a 30 day period will result in a discharge from the clinic.

If you arrive more than 15 minutes late for your scheduled appointment time, please understand that you may be asked to reschedule your appointment. This will be at the therapists' discretion.

Worker's Compensation - Any missed or cancelled appointments are required by contract to be forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits you may be entitled to.

Please sign below to consent to these terms.

_____

Patient Signature (Patient's Parent/Guardian if under 18)

_____

Date

Please initial if you would like an appointment reminder call and/or text and provide a valid number to be reached at and we will send a reminder notification one day in advance.

_____ Text _____ Call _____Text & Call

(_____) _____ - _____

Cell Phone carrier:_____