Chaparral Physical Therapy

525 Melissa Ave. • Barstow, CA 92311 • 760-256-1888

Private Insurance ◌ Medicare ◌ MediCal ◌

Patient Information

Patient Name ______________________________ Date of Birth____________

Mailing Address________________________ City________ State _____ Zip_____

Home Phone ____________ Mobile Phone ____________ SSN________________

Date of Injury ____________ Referring Doctor ____________ Phone ____________

Emergency Contact ______________________________ Phone ____________

How did you hear about us?

☐ Doctor ☐ Family member ☐ Friend ☐ You were a previous patient ☐ Other

Employer Information

Employer ______________________________ Phone ____________

Primary Insurance

Insurance Carrier ______________________________ ID # ________________

Name of Insured / Sponsor ________________ Relationship __________ DOB________

Secondary Insurance

Insurance Carrier ______________________________ ID # ________________

Name of Insured / Sponsor ________________ Relationship __________ DOB________

Please Describe Your Injury Or Illness (What are we treating you for?)

____

____

ALL PATIENTS: Is your injury the result of a MOTOR VEHICLE ACCIDENT? Y N
MEDICARE PATIENTS: Are you receiving any type of HOME HEALTH CARE? Y N

Medicare will not pay for physical therapy if patient is receiving home health care. Please note that you will be held responsible for any charges if payment is denied due to home health care issues. Please inform our staff immediately if home health care is initiated after physical therapy treatments begins so other payment options may be reviewed.

MEDICARE patient's signature ________________________

I authorize payment of benefits directly to the supplier for medical services described on the attached claim form. I realize this may not represent full payment for services rendered and I will be responsible for balance due. I hereby authorize Chaparral Physical Therapy to release any information acquired in the course of my examination and treatment. I also acknowledge that I have read the *Privacy Practices* provided to me by Chaparral Physical Therapy and understand the legal duty of the provider, the uses and disclosures of health information, and my rights.

Patient Signature ______________________________ **Date** ________________

525 Melissa Ave. • Barstow, CA 92311 • 760-256-1888

LAST NAME ______________________ FIRST NAME ______________________

Have you had surgery for ***this*** injury? Y ☐ N ☐ If yes, how many? __________

Have you had any of the following medical or rehabilitive service for ***this injury/episode***?:

Service	Y	N	Service	Y	N
Chiropractor	☐	☐	MRI	☐	☐
EMG / NCV	☐	☐	Neurologist	☐	☐
Massage Therapy	☐	☐	Orthopedist	☐	☐
Occupational Therapy	☐	☐	Podiatrist	☐	☐
Physical Therapy	☐	☐	X-Rays	☐	☐
Emergency Room Care	☐	☐	CT Scan	☐	☐

Do you now have or have you **ever had** any of the following?:

Condition	Y	N	Condition	Y	N
Asthma / Bronchitis / Emphysema	☐	☐	Osteoporosis	☐	☐
Shortness of Breath / Chest Pain	☐	☐	Sleeping Problems	☐	☐
Coronary Heart Disease / Angina	☐	☐	Psychological Problems	☐	☐
Pacemaker	☐	☐	Severe or Frequent Headaches	☐	☐
High Blood Pressure	☐	☐	Vision / Hearing Difficulties	☐	☐
Heart Attack / Heart Surgery	☐	☐	Numbness or Tingling	☐	☐
Stroke / TIA	☐	☐	Dizziness or Fainting	☐	☐
Blood Clot / Emboli	☐	☐	Bowel / Bladder Problems	☐	☐
Epilepsy / Seizures	☐	☐	Allergies	☐	☐
Infectious Diseases	☐	☐	Pins or Metal Implants	☐	☐
Diabetes	☐	☐	Cancer or Chemo / Radiation	☐	☐
Arthritis	☐	☐	Are you pregnant	☐	☐

Current medications include ______________________________

____

____

INFORMED CONSENT

I agree to participate in physical therapy at Chaparral Physical Therapy. I understand that my program may include progressive range of motion, manual techniques (mobilization, manipulation, soft tissue mobilization, massage, manually resisted exercises, etc.), therapeutic exercises (land-based or aquatic), various modalities (electrical, mechanical, heat or ice applications, etc.), ultrasound, iontophoresis (the topical application of steroids or other compounds using electrical devices) or other conventional physical therapy techniques.

I understand that it is extremely important that I understand these instructions, and that I should ask any and all questions I may have prior to beginning any treatment.

I understand that there exist certain risks while participating in physical therapy that include, but are not limited to, muscle and/or joint soreness, increased pain, bruising, tissue tenderness, blood pressure changes resulting in dizziness or possible fainting, irregular heartbeat, and in very rare cases skin burns, bone fractures, cardiac arrest or other medical problems which could result in severe disability or even death.

I understand that every effort will be made to minimize my risk by properly screening me with a preliminary history and physical evaluation. I understand that certain limits will be set on my exercise program based on the results of my evaluation and that I must not exercise beyond the limits set forth in my exercise program. By doing so, I increase the risk of injury resulting in more severe disability or even death.

I understand that I will be instructed regarding the signs and symptoms which I should report immediately to the supervisor of the treatment I am receiving or the exercises I am performing and which will alert me to modify my activities. I understand that I must advise the monitoring therapist should I experience symptoms I have not normally experienced during previous exercise. I understand that I will be instructed in the safe use and operation of all exercise equipment for use in my exercise program.

Understanding the risks, and potential benefits, involved in participation in therapy at Chaparral Physical Therapy and Sports Medicine, I voluntarily choose and consent to participate. I accept and assume the risks involved in doing so.

I reserve the right to refuse any aspect of suggested care.

______________________ ___________

Patient Signature Date

Consent To Use Or Disclose Health Information

I authorize Chaparral Physical Therapy Inc to use and disclose the health information of
___________________________________ for the purposes of
(Name of Patient)
Treatment, Payment, and Health Care Operations.*

Treatment: includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physical therapist that covers our practice as the on-call therapist.

Payment: includes activities involved in determining your eligibility for health plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations: includes the necessary administrative and business functions of our office.

You may review Chaparral Physical Therapy's "Notice of Privacy Practices" for additional information about the uses and disclosures of information in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: ______

Because we have reserved the right to change our policy practices in accordance with the law, the terms contained in the Notice may change as well. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right-hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then-current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and healthcare operation purposes. We are not required to agree to you request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other therapists who provide call coverage for your office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Chaparral Physical Therapy, has already used or disclosed the information in reliance on the Consent.

____
Signature of Patient

____
Signature of Person authorized by law (if other than patient)

____
Date

CANCELLATIONS AND NO SHOWS

Chaparral Physical Therapy schedules personnel to attend to patients needs as prescribed by the referring Physician.
When a patient does not show or cancels on the same day of his/her scheduled appointment; personnel must be sent home due to lack of work.
We will not overbook to compensate for no shows or cancelations because you, the patient; will not receive the attention you need and deserve.
We ask your cooperation to avoid these problems.
Chaparral Physical Therapy reserves the right to assess a $30 charge per no show or same day cancelation which could be enforced upon the third occurrence.

I ___________________have read and agree to the above terms.

___________________ __________

Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Chaparral Physical Therapy** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by **Chaparral Physical Therapy** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Chaparral Physical Therapy** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Tracy L Malan,** 525 Melissa Ave., Barstow, CA 92311, 760-256-1888

With this consent **Chaparral Physical Therapy** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent **Chaparral Physical Therapy** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Chaparral Physical Therapy** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Chaparral Physical Therapy** restrict how it uses or discloses my **PHI** to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by, this agreement.

By signing this for, I am consenting to allow **Chaparral Physical Therapy** to use and disclose any **PHI** to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Chaparral Physical Therapy** may decline to provide treatment to me.

________________________________ ________________________
Signature of Patient or Legal Guardian Print Patient's Name

____ ______________
Print Name of Patient or legal Guardian, if applicable Date