Restor Physical Therapy

P.O. Box 8125
Fountain Valley, CA 92728-8125
Office: 714-754-7268
Fax: 714-434-7042

Last Name: _____ First Name: _____ M I: _____ M/F _____

Address: _____ City/State/Zip _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Date of Birth: _____ SS#: _____ Referring Physician: _____

Primary Care Physician, if other than referring Physician: _____

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

**********BILLING INFORMATION**********

Related to Work Injury or Automobile - Yes or No: _____ Date of Injury: _____

Claim #: _____ Auto – Do you have MedPay on Policy: _____

IF OTHER THAN ABOVE:

Relationship to the Insured for Primary Insurance: Self Spouse Child Other

Insured's Employer _____

Relationship to the Insured for Secondary Insurance: Self Spouse Child Other

Insured's Employer _____

Are you presently receiving Home Health Care? (Yes or No) i.e. home companion, visiting nurse

Name of Agency _____

Have you recently finished Home Health Care? (Yes or No)

Name of Agency _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder Name: _____

**********HIPAA**********

I have been offered a copy of the notice of privacy practices and have accepted or denied the offer. I give my consent that my health information cam be used for the purpose of treatment, payment, and health care operations.

Signature: _____ Date: _____

**********PAYMENT POLICY**********

I authorize payment to be made and/or sent directly to Restor Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my Deductible and or Copayment upon each visit. I understand that verification of my Insurance does not guarantee payment from My Insurance Company and that I will be responsible for payment to Restor Physical Therapy if Insurance denies payment.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Chief Complaint/ Ailment / Injury: _____

Date of Injury: _____ Date of Surgery: _____

Briefly Describe How You Were Injured and Describe Pain Symptoms:

_____

Have You Received Therapy For This Condition? Yes or No When? _____
HOW MANY VISITS DID YOU RECEIVE? _____

Has Your Condition Been Getting: ___ Worse ___ Same ___ Better
Are Your Symptoms: _____ Constant or _____ Intermittent

Have you had surgery for this injury? Yes No Number of surgeries: 1 2 3 4 5 6

Type of surgery: _____

List of your **current** prescription and/or non-prescription medications: _____

_____

Have you had any of the following medical or rehabilitative services for **this** injury or episode?

	YES	NO		YES	NO
Physical Therapy	____	____	MRI	____	____
Massage Therapy	____	____	X-rays	____	____
Chiropractic	____	____	CT scan	____	____
Podiatrist	____	____	EMG/NCV	____	____
Neurologist	____	____	Myelogram	____	____
Orthopedist	____	____	Injections	____	____
Other _____					

Do you **Now** have ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or frequent headaches	____	____
Shortness of breath/chest pain	____	____	Numbness or tingling	____	____
High Blood Pressure	____	____	Dizziness or Fainting	____	____
Epilepsy/Seizures	____	____	Bowel or Bladder Problems	____	____
Thyroid disease or Goiter	____	____	Weakness/Energy Loss	____	____
Anemia	____	____	Weight Loss/Gain	____	____
Diabetes/Type_____	____	____	Any pins or metal implants	____	____
Arthritis/Where_____	____	____	Emotional/Psychological	____	____
Osteoporosis	____	____	Are you pregnant?	____	____
Sleeping difficulties	____	____	Do you smoke?	____	____

Have you **EVER** had any of the following?

Coronary heart disease or Angina	____	____	Vision or hearing difficulties	____	____
Do you have a pacemaker?	____	____	Hernia	____	____
Heart Attack/	____	____	Varicose Veins	____	____
Stroke/TIA	____	____	Allergies	____	____
Congestive Heart Disease	____	____	Joint replacement surgery	____	____
Blood clot/Emboli	____	____	Neck injury/surgery	____	____
Infectious disease	____	____	Back injury/surgery	____	____
Cancer/Type _____	____	____	Shoulder injury/surgery	____	____
Gout	____	____	Knee injury/surgery	____	____
Ankle/foot injury/surgery	____	____	Elbow/hand surgery/surgery	____	____

RESTOR PHYSICAL THERAPY
P.O. BOX 8125
FOUNTAIN VALLEY, CA 92728-8125
PHONE: 714-754-7268 FAX: 714-434-7042

Confidential Channel of Communication Request

As required by the Health Information Portability and Accountability Act 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 every effort 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 or treatment. This request supersedes any prior request for confidential channel communications I have made.

What telephone number(s) may we use to contact you?

Home: _____ Cell: _____

What email address may we use for correspondence? _____

Please circle your choice response to the following questions:

May we leave messages concerning your appointments/treatment with a co-worker, receptionist, or secretary that regularly answers your calls? Yes No

May we leave messages on a voice mail at work? Yes No

May we leave messages on an answering machine at home? Yes No

May we leave information with a spouse or significant other? Yes No

Is there anyone that is not listed above that we can give information to? If so, please specify. Yes No

Name_____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

For any children above 18, still living at home, may we discuss your appointments/treatments? Yes No

You must inform us, in writing, of any changes in your directives. This record takes effect August 5, 2013 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

You may contact our privacy officer Robin R. Wells at (714) 754-7268.

Patient Name: _____ Date: _____
(Please print)

Signature: _____ Date of Birth: _____

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Consent to Treatment and Conditions of Treatment

Consent to Treatment: I _____

Consent to the procedures, which may performed during my treatment and care at RESTOR PHYSICAL THERAPY, including emergency treatment or services. These may include but are limited to therapeutic test, treatments and procedures, manipulation, stretching, or exercise treatment or procedures as directed under the general instructions of the Physical Therapist or Aide. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs relating to my physical condition as are deemed necessary.

Release of Information: RESTOR PHYSICAL THERAPY is authorized to release any information necessary, including copies of my Therapy and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide to RESTOR PHYSICAL THERAPY information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by the patient.

Financial Agreement/Assignment of Benefits: I assign any and all insurance benefits payable to me to RESTOR PHYSICAL THERAPY. I understand that I am responsible for payment of services rendered by RESTOR PHYSICAL THERAPY including excluded services from my insurance either because of the plans deemed such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney and/or collection expenses. I, the undersigned, state that the information that I have provided RESTOR PHYSICAL THERAPY is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement.

_____ Date _____
Signature of Patient or Representative

_____ Date: _____
RESTOR Physical Therapy Representative

Restor Physical Therapy, Inc
P.O. Box 8125
Fountain Valley, CA 92728-8125
Phone: 714-754-7268 Fax: 714-434-7042

Cancellation / No Show Policy

Private Insurance and Medicare Patients:

Any No Show or Cancellation that are not made 24 hours prior to your scheduled appointment time are subject to a $50.00 Cancellation Fee, which will be your responsibility. This cannot be billed to your Insurance Company.

Workers Compensation Patients:

Workers Compensation Patients will be reported to your Work Compensation Insurance Adjuster for ALL No Show and Cancellation of Appointments.

Cell Phones:

As a courtesy of others, cell phone use is strongly discouraged during all treatment sessions. We ask that you please turn off your phone and set it to silent mode before your treatment appointment.

Print Name: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Name of Patient: _____

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AUTHORIZATION FOR RELEASE OF RECORDS

This Authorization for disclosure and release of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et. Seq., of the California Civil Code, the Health and Safety Code, Section 199.21

I Authorize Restor Physical Therapy to release my private health information as specified below to:
Name: _____ (Doctor, Ins. Agent, Self)

Address: _____

City, State and Zip_____

Fax#: _____ Office#: _____

This authorization is limited to the following information only: ___ Physical Exam ___ X-ray Report / Film ___ Physical Therapy Notes ___ Lab Reports ___ Progress Notes ___ Complete Medical Records ___

Other, please specify: _____

Duration: This authorization is valid from _____ to _____ (not to exceed 1 year)

• I understand that I have the right to receive a copy of this authorization upon my request. • I understand that I may not be required to sign this authorization as a condition to obtain treatment or obtain my eligibility benefits.

• I also understand that I may revoke this authorization in writing at any time by sending a notice to the custodian of records. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this authorization.

• I understand that Restor Physical Therapy is required to keep my health information confidential, and re-disclosure of my health information without my authorization is prohibited by state and federal law.

• I further understand that the potential exists for re-disclosure of my private health information and it may no longer be protected under HIPAA, if I choose to disclose my private health information to someone who is not legally required to keep it confidential. • I also understand that I am entitled to receive notice if my protected health information has been breached.

Signature of Patient: _____ Date: _____

Print Name: _____ DOB: _____

Restor Physical Therapy accepts cash, check, and credit card as a form of payment. Checks should be made payable to Restor Physical Therapy. Please be advised that we may have to get prior approval from a provider if your results have not yet been discussed with you, before releasing your records. It is our policy not to accept subpoenas by mail. Any subpoena must be served in person and delivered to Restor Physical Therapy. Particular diagnoses are protected by specific laws, which may require a different authorization form.

HIPAA Notice of Privacy Practices

RESTOR PHYSICAL THERAPY
P.O. BOX 8125
FOUNTAIN VALLEY, CA 92728-8125
PHONE: 714-754-7268 FAX: 714-434-7042

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.
2. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see vu: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.
3. These situations include: as required by Law, Public Health issues as required by law, Legal Proceedings: Law Enforcement.
4. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information.

5. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
6. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
7. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
8. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
9. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
10. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
11. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on or before April 14. 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Robin R Wells our HIPAA Compliance Officer in person or by phone at 714-754-7268.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

A. **Notifier:** Restor Physical Therapy
351 Hospital Road #007
Newport Beach, CA 92663

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. services** below, you will be responsible for all charges. Medicare does not pay for everything, even some care that you or your health care provider have Good reason to think you need. We expect Medicare may not pay for the **D services** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. **Physical Therapy services in excess of Medical Necessity or if a claim is denied for payment for any reason.**	**Medicare bases physical therapy on Medical Necessity.**	**Approx. $120.00 per visit Depending on treatment plan.**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Services** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision.

If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: