David K. Thomas, PT, MPA, Owner

El Dorado Hills (916) 933.1221
907 Embarcadero Drive, 95762

Folsom (916) 355.1250
990 Riley Street, 95630

Shingle Springs (530) 677.5092
4052 Mother Lode Dr., 95682

El Dorado Hills Sports Clinic (916) 933.1090
8135 Saratoga Way, Ste. 200, 95762

Central FAX (916) 933.0871

www.eldoradopt.com

Welcome to El Dorado Physical Therapy. The purpose of this letter is to provide you with some helpful information to prepare you for your first visit to the facility.

Prior to your evaluation being scheduled your primary insurance will be verified and if necessary authorization obtained. If there is secondary insurance that also will require verification and authorization. It is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding copays, deductibles, referrals, etc. Please remember that benefits quoted are not a guarantee of payment per your insurance.

The scheduler will call to schedule your evaluation and subsequent session. At that time you should have a prescription from your physician to evaluate and treat you or your child. Any questions regarding the scheduling of evaluations should be directed to the scheduler at the clinic phone listed above.

When you arrive for the evaluation please come to the Reception Desk in the Outpatient area and have with you:

1. **The script from your physician to evaluate and treat «Client Full Name»**
2. Your insurance card.
3. Any copays or referrals as required by your insurance company.
4. Copy of your driver's license or of the parent or legal guardian.

Please have all of the above items with you when you arrive or it will be necessary to reschedule your appointment.

After the evaluation has been completed, the therapist will discuss with you a treatment program.

If you have any questions or I can be of any assistance to you please call me at «Clinic Phone»,

We look forward to seeing you.

Sincerely,

El Dorado Physical Therapy

EL DORADO PHYSICAL THERAPY – PATIENT HEALTH HISTORY page 1

PRINT NAME: _____ DOB: _____ AGE: _____ GENDER: M F

1. Describe what you are being treated for:

_____

2. When did your symptoms begin? _____

3. Is this injury as a result of a motor vehicle accident? **Yes / No** If yes, what State did this happen in? ____

4. Is this Workers Compensation related? **Yes / No**

5. What caused your symptoms? _____

6. Did you have surgery for this? Yes / No Date of surgery: _____

7. Did you receive Home Health care after your surgery? Yes / No Date of discharge: _____

8. Circle all symptoms you are <u>currently</u> having?
Swelling Loss of Motion Weakness Pain Stiffness Loss of Balance Numbness Tingling Other:

_____

9. Circle the number that represents your current pain level: (0 = No Pain & 10 = Worst Pain)
0 1 2 3 4 5 6 7 8 9 10

10. Circle the number that represents the least amount of pain you've had with this injury: (0 = No Pain & 10 Worst Pain)
0 1 2 3 4 5 6 7 8 9 10

11. Circle the number that represents the worst level of pain you have had with this injury: (0 = No Pain & 10 Worst Pain)
0 1 2 3 4 5 6 7 8 9 10

12. What activities increase your symptoms? (ex: sitting, walking, driving)

_____

13. What eases your symptoms? (ex: ice, rest, lying on your side)

_____

14. Do your symptoms interrupt your sleep? **Yes / No**

15. Since this condition began, have your symptoms: **Decreased Increased No Change**

16. Have you had tests for this condition? **Yes / NO X-ray MRI Other:** _____
When & Where: _____

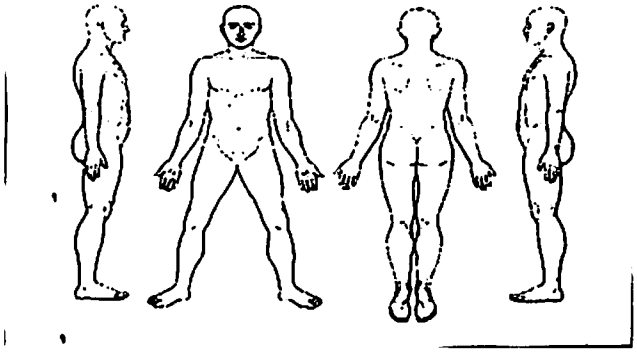
17. What treatments have you received for this condition?
Rest Exercise Physical Therapy Chiropractic/Acupuncture Medications Heat or Ice Other:

_____

EL DORADO PHYSICAL THERAPY – PATIENT HEALTH HISTORY - page 2

PRINT NAME: _____ DOB: _____

18. Please use these symbols to note symptom location: ^^^Numbness *** Pins & Needles /// Pain



19. Do you have any of the following medical conditions? (Circle all that apply)

Heart Disease	**High Blood Pressure**	**Pacemaker**	**Diabetes**
Seizures	**Asthma/Allergies**	**Metal Implants**	**Gout**
Strokes/CVA	**Circulation Problems**	**Osteoporosis**	**Arthritis**
Cancer	**Pulmonary Disease**	**Liver Disease**	**Thyroid Disease**
Kidney Disorders	**Autoimmune Disorder**		

20. Are you currently experiencing any of the following? (Circle all that apply)

Headaches	**Dizziness**	**Recent weight loss or gain**	**General Fatigue**
Easy Bruising	**Numbness/Tingling**	**Fever/Chills/Sweats**	**Nausea/Vomiting**
Depression	**Anxiety/Panic Attacks**	**Sensitivity to heat or cold**	**Muscle Weakness**
Shortness of breath	**Swollen Legs or Feet**	**Drug/Alcohol Dependence**	

21. Please list any medical conditions that have not been documented above:

_____

22. Have you fallen at any time in the past 12 months? **Yes / No** If so, how many times? _____

23. Are you allergic to latex? **Yes / No**

24. Are you allergic to steroids? **Yes / No**

25. Are you pregnant? **Yes / No**

26. Do you smoke? **Yes / No**

27. Please list any activities or sports you are currently involved in:

_____

28. What goals or activities do you want to achieve with Physical Therapy?

_____

PRINT NAME: _____ DOB: _____

CURRENT MEDICATION LIST - Please list all over the counter medications, herbals, vitamins, minerals, and dietary supplements. If you are not taking any medications or supplements, please write none on the first line.

	Start Date	Name of Medication	Dosage	Frequency	What is this medication for?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

If you require an additional form for medications, please ask our front desk. If your medications change, please notify our staff immediately so we can update your information.

As part of your treatment we may need to administer treatment in a group setting (i.e. a common treatment area or gym). In such situations, some of your personal health information may be disclosed. We will do our best to keep disclosures to a minimum.

To refuse treatment in a group setting (treatment will be provided in a private room). _____ (please initial)

_____

Patient or Parent/Legal Guardian Signature **Date**

_____

Printed Name of Parent or Legal Guardian, if applicable **Relationship**

El Dorado Physical Therapy Insurance & Financial Policy

Folsom 916-355-1250 El Dorado Hills 916-933-1221 Shingle Springs 530-677-5092 EDH Sports Clinic 916-933-1090

Patient Name:_____ **Date:**_____

Insurance Benefits: We bill your insurance carrier as a courtesy to you. It is recommended that you call the Member Services department at your insurance company and verify what your responsibilities may be regarding co-pays, deductibles, referrals, prior authorizations, etc. If your insurance determines your Therapy Services do not meet their medical necessity guidelines, the denied charges will be applied to the patient's responsible balance. Disputes regarding benefits are between the patient and the insurance company.

Please notify our office immediately if your insurance carrier or type of coverage should change. Failure to notify our office of any change may result in denial by the insurance company, in which case payment becomes patient responsibility.

In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us.

_____ **Initial Here: Co-payments:** Per your insurance agreement and our contracting guidelines, co-payments are due at the time of service, unless you have a Quick Pay Agreement on file.

Assignments of Insurance Benefits: I hereby authorize El Dorado Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

If your bill has not been paid within 30 days from the date on your bill, a 1.5% per month Finance Charge 18% per annum will be applied. If formal collection procedures become necessary you will be responsible for additional costs incurred.

Non-Sufficient Funds, Cancellation and No-Shows: Checks returned for Non-Sufficient Funds will be subject to a $25 processing fee. *We require least 24-hours notice to reschedule or cancel an appointment.* This allows adequate time to assign this appointment to another patient who is in need of this appointment time. If an appointment is rescheduled, canceled or missed with less than 24 hours notice, we may charge a $50 fee. This charge is not covered by insurance and will be your responsibility.

_____ **Initial Here: Consent for Treatment:** Your Physical Therapist will complete an evaluation by interview and examination. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned to hereby agree and give my consent for El Dorado Physical Therapy to furnish physical therapy and treatment considered necessary and proper in evaluating or treating my physical condition.

_____ **Initial Here: Consent for Treatment of a Minor:** As parent and/or legal guardian, I authorize El Dorado Physical Therapy to treat _____ (minor's name) while I am not present. Quick Pay Agreements are required to be on file for minors that are unaccompanied by a parent or guardian.

HIPAA – Patient Consent: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information, about the patient, used to carry out treatment, payment or Health Care operations.

We respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum amount of information needed regarding treatment, payment or health care operations in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. At times we may need to disclose personal health information for purposes of treatment, payment of health care operations. In such situations your consent may not be required.

El Dorado Physical Therapy Insurance & Financial Policy

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You may refuse to consent to the use or disclosure of you personal health information, but this must be done in writing. Under HIPAA regulations, we have the right to refuse to treat you should you choose to refuse disclosure of your Personal Health Information. If you choose to give consent in the document, you may later revoke all or part of your consent. However, this will not affect actions that have already taken place relying upon this or any other previously signed consent.

If you would like to authorize El Dorado Physical Therapy to release your PHI to any other party other than referring doctor and your billing insurance company, you must specify names here. (Example, if a family or friend might call us to cancel or reschedule an appointment on your behalf or discuss insurance issues. If left blank, we are only speaking with you.)

Full Name **Relationship**

1._____

2. _____

3. _____

Appointment Reminders Step One: Select *One* Option Below

☐ El Dorado Physical Therapy may send email messages to confirm my upcoming appointments to _____

☐ El Dorado Physical Therapy may send cell phone *text messages to confirm my upcoming appointments to _____

normal text messaging rates may apply.

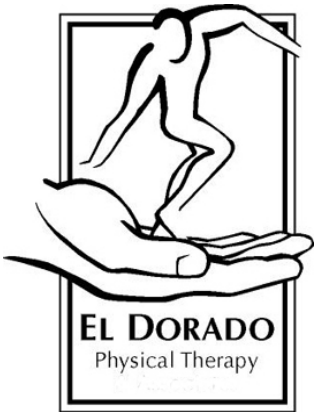
Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ Boost Mobile
- ☐ Cricket Wireless
- ☐ MetroPCS
- ☐ Qwest
- ☐ TMobile
- ☐ Verizon
- ☐ AT&T
- ☐ Cingular
- ☐ Metrocall
- ☐ Nextel
- ☐ Sprint PCS
- ☐ US Cellularl
- ☐ Virgin Mobile

Printed Patient Name:_____ **Date:** _____

Patient/Responsible Party Signature: _____ **Relationship:**_____



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COPAY / QUICK PAY AGREEMENT

Your privacy is important to us, all records are kept securely in our billing office.

For your convenience you are welcome to put a credit card on file to take care of your copays and/or balances. *Your privacy is important to us, all records are kept securely in our billing office.*

Patient Name: _____ **Account #:** _____

I, _____, authorize El Dorado Physical Therapy to charge my card listed
(carholder name) below, for charges indicated.

- ◯ **Copay and Cash patients *charged on the day of service***
  Card on file required for all patients with copays or cash patients
- ◯ **Total responsible balance due -*select one option*:**
  ◯ every Friday ◯ 5th of the month ◯ 15th of the month ◯ 25th of the month
- ◯ **$_____ maximum amount of responsible balance to charge each week**

Card #__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp__ __/__ __ Code__ __ __

Name as it appears on card: _____

Unless other arrangements are made, this authorization is to remain in effect until patient is discharged and account is paid in full.

_____ _____

Authorized signature **Date:**

Email address for receipts: _____ _____

~~~~~~

For office use only:

Treating Clinic: _____ Insurance: _____

Copay: $_____ Deductible: $_____ Co_ins:_____%
~~~~~~