400 S. Reino Road, Suite #101
Newbury Park, CA 91320

reCOOPERation PHYSICAL THERAPY
SYMMETRY IN BALANCE AND MOTION

P: 805.277.2233
F: 805.277.0623

PATIENT INFORMATION

Today's Date:				
PATIENT INFORMATION (PLEASE PRINT)				
Patient's LAST Name:	**FIRST Name:**	**Middle:**	■ Mr. ☐ Miss ☐ Ms. ☐ Mrs.	
			Sex: ■ M ☐ F	
Date of Birth:	Age:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Street address:		Driver's License #:	State Issued:	
City:	State:	Zip Code:	Email Address:	
Home Phone:	Cell Phone:	Work Phone:		
Occupation:	Employer:	Employer Address:		
Insurance Subscriber Name (if different than patient) :		Subscriber DOB:	Patient Relationship to Subscriber:	
Referring Doctor		Other family members seen here (if any):		
ADDITIONAL INFORMATION				
****Please give your insurance card to the Front Desk****				
Date of Injury(if known):		Is this injury work related? ☐ Yes ☐ No		
If yes, Industrial Insurance name and address:				
If work related, employer at the time of injury:				
Is injury related to an accident?	☐ Auto:		☐ Other:	
Are you involved in a lawsuit and/or are you pursing a third party liability claim as a result of this injury?	☐ Yes ☐ No	If yes, name and address of attorney:		

I hereby irrevocably authorize payment of medical services rendered to my dependents or myself directly to Recooperation Physical Therapy. I also authorize Recooperation Physical Therapy to furnish my insurance with full information regarding treatment provided to my dependents or myself. I also understand that my insurance is billed as a courtesy, and that I am responsible for all charges not paid by my insurance within 8 weeks after billing date. I further understand that any supplies given to my dependents or myself may not be covered by my insurance; for this reason it is customary to collect supplies at the time of service. By signing below, you are confirming that all information above is truthful and filled out to the best of your ability and the photo-static copy of your insurance card is valid.

Patient/Guardian signature:	***Date:***

Patient Intake Form

Name:_____ **Date of Birth:**_____

Referring Doctor: _____ **Primary Doctor:**_____

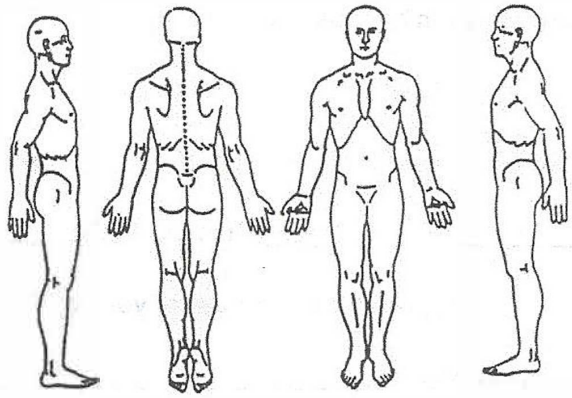
What is your primary reason for physical therapy? _____

_____

_____

How long has your problem been bothering you? _____

Please mark areas of concern on the diagram below:



Medical History (Please check all that apply)

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ History Of Cancer
- ☐ Neurologic Disorder
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Spinal Cord Injury
- ☐ Brain Injury
- ☐ Systemic Infection
- ☐ Autoimmune disease
- ☐ Chronic Pain Disorder
- ☐ Fracture
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Pregnancy (current or recent)
- ☐ Tobacco use
- ☐ Substance abuse
- ☐ Other (enter description below)

If yes to any of the above, please specify: _____

_____

_____

Please List your Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you recently or are you currently experiencing any of the following symptoms?

- ☐ Trouble with sleeping
- ☐ Bowel or bladder changes
- ☐ Dizziness or vertigo
- ☐ Sensation changes (numbness, tingling, etc)
- ☐ Recent change in your weight or appetite
- ☐ Temperature Sensitivity
- ☐ Bruising or bleeding disorders
- ☐ Skin changes, rashes, or discoloration
- ☐ Visual changes
- ☐ Nausea/vomiting
- ☐ Shortness of breath or decrease in stamina?
- ☐ Do you use any assistive devices

Please Specify: _____

Are there any other concerns we need to be aware of during your care? _____

_____

How would you rate your general health? (Circle one)

Poor Fair Good Very Good Exceptional

Overall activity level: (circle one) Sedentary Light Moderate Heavy

Primary Exercise or Sport: _____ **Time per Week:** _____

Are you currently working?_____ **If so, what is the nature of your work?** _____

What are your goals for physical therapy? _____

_____

Who can we thank for this referral? _____

Thank you for your patience and valuable time!

Consent for Care and Treatment

I, (PRINT)_____, do hereby agree and give my consent for RECOOPERATION PHYSICAL THERAPY to furnish medical care and treatment which is necessary and proper for diagnosing and treating his/her physical and/or mental condition.

Patient/Guardian Signature _____ Date _____

Benefit Assignment/Release of Information

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to RECOOPERATION PHYSICAL THERAPY. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian Signature _____ Date _____

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Financial Policy

We bill your insurance carrier solely as a courtesy to you. You are responsible for unmet deductibles as well as any co-pay/co-insurance at the time of your visit. If for any reason your insurance carrier pends or denies your claim, it is the patient's responsibility to pay the remaining balance. If at any time your claim has to be reviewed for medical necessity, the patient is required to cover all expenses until we are notified of the final decision. You will be refunded if, and when the insurance approves additional visits. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. All patients are responsible to know their plan limits and their visit usage; if there are any questions regarding your policy or visits, feel free to ask.

If you are billed directly for any services, please promptly remit the payment to RECOOPERATION PHYSICAL THERAPY.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if your W/C benefits and are subsequently denied, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Cancellation Policy

- Patients will be charged $20 for same day cancellation or missed appointments.
- A missed appointment charge is not a fee for health care services, but rather, it is a "charge for missed business opportunity".
- Your insurance carrier cannot reimburse for this charge, it is the patient's responsibility.

Thank you for giving us at least 24 hours' notice if you need to cancel your appointment!

_____ _____

Patient/Guardian Signature Date

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Notice of Privacy Practices

We protect the privacy of our patient's health information by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

Your Health Information
This notice describes how your medical information about you may be used and disclosed and how you can get access to this information, please review carefully.

We collect, use, and disclose information provided by you and about you for medically necessary treatment, health care payment and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist. As permitted or required by law: Information provided by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcements official, such as to comply with a court order or subpoena.

Authorization: Other used and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used you information based on your authorization, you cannot take back your agreement for those past situations.

Your rights:
Under regulations that went in to effect on April 14, 2003 you have additional rights over your health information. Under the new rules, you have the right to:

- Send usa written request to see or get a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or healthcare operations, or the law otherwise restricts the accounting.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Charges
You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contact Information
If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact our privacy officer at: (805) 277-2233

Declaration of Privacy of Health Information
All medical records and other individual identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper or orally are covered by the US Department of Health and Human Services(HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996)

Further, I authorize that the results of any assessments or records given to me may be used in completing evaluation, assessments, treatments, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information.

I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors and administrators.

Restrictions requested by patient:

_____
_____
_____
_____
_____
_____

Signature of patient:_____Date:_____