Fuqua PT

6560 Greenback Lane, Citrus Heights, CA 95621
(916) 723-3042 Fax (916) 723-1638

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

FUQUA PHYSICAL THERAPY'S LEGAL DUTY

Fuqua 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 described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Fuqua 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, Fuqua 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.

Fuqua Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Fuqua Physical Therapy's policy is to obtain 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 further disclosures at any time.

Fuqua 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 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.

PATIENTS 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 fist 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. Fuqua 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 Fuqua 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 Health and Human Services. For further information on Fuqua Physical Therapy's health information practices or if you have a complaint, please contact the following person:

FUQUA PHYSICAL THERAPY, MARSHANN FUQUA, TEL: (916) 723-3042 EXT. 104 FAX: (916) 723-1638

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PAST MEDICAL HISTORY FORM

Patients Name: _____ Date: _____

Are you presently working? ☐Yes ☐ No Date of next physician's visit: _____

1. Date of injury / onset: _____

2. Have you ever had these symptoms before? ☐ Yes ☐ No

3. Check all that apply:

☐ Work related injury ☐ Motor vehicle accident ☐ Cause unknown
☐ Recurrence of previous injury ☐ Injury related to lifting ☐ Motor vehicle
☐ Other: _____

4. Have you had a related surgery: ☐ Yes ☐ No

5. Do you have or have you ever had any of the following:

☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Allergies to Aspirin
☐ Yes	☐ No	Chest Pain / Angina	☐ Yes	☐ No	Allergies to Heat
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Allergies / poor tolerance to cold
☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Other Allergies
☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Hernia
☐ Yes	☐ No	Heart Palpitations	☐ Yes	☐ No	Seizures
☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Metal Implants
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Dizziness / Fainting
☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Recent Fractures
☐ Yes	☐ No	Are you pregnant:	☐ Yes	☐ No	Surgeries
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Skin Abnormalities
☐ Yes	☐ No	Bowel / Bladder problems	☐ Yes	☐ No	Sexual Dysfunction
☐ Yes	☐ No	Abnormalities	☐ Yes	☐ No	Nausea / Vomiting
☐ Yes	☐ No	Asthma / Breathing Difficulties	☐ Yes	☐ No	Ringing in your ears
☐ Yes	☐ No	Liver / Gallbladder Problems	☐ Yes	☐ No	Rheumatoid Arthritis
☐ Yes	☐ No	Other	☐ Yes	☐ No	Special Diet Guidelines
☐ Yes	☐ No	Smoking	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	HIV / A.I.D.S.			

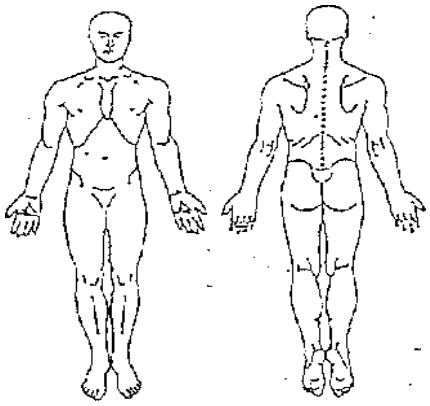
If yes on any of the above, briefly explain and give approximate date:

6. Are you presently taking medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition:

7. Rate the intensity of your pain and on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____

8. Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No

PLEASE INDICATE BELOW WHERE YOUR PAIN IS:



_____ _____ _____
Signature Relationship to Patient (if a minor) Date

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FINANCIAL POLICY

My signature on this office financial policy form will confirm that the information contained herein is correct. I understand that if any information is incorrect, it is my responsibility to notify the office staff so the necessary correction(s) can be made.

Furthermore, I understand that I am financially responsible for all services rendered, unless this is an accepted worker's compensation claim. I understand, that I am responsible for co-payment (patient portion not covered by health insurance) on each visit unless other arrangements have been made with the office staff. There will be a $15.00 service fee for any returned checks.

In the event legal action is necessary to recover the monies due to Fuqua Physical Therapy, I understand that I will be responsible for any and all fees associated with satisfaction of the outstanding balance.

In case of emergency contact:

Name: _____ Phone: _____

Relationship: _____ Other: _____

RELEASE OF INFORMATION

Authorization to release information: I hereby authorize the release of information deemed necessary to my doctor and insurance company by Fuqua Physical Therapy.

Patients Name (printed): _____

Patients Signature: _____

Date: _____

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CONSENT TO TREAT

I understand that I have been referred for rehabilitative treatment and care to Fuqua Physical Therapy. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Fuqua Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

I consent to and authorize Fuqua Physical Therapy to administer all treatment and services that maybe considered advisable in the judgment of my physician and/or therapist in accordance with Fuqua Physical Therapy policies.

Patient Name (printed): _____

Patients Signature: _____

Date: _____

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Fuqua Physical Therapy's Notice of Information Practices. I understand that Fuqua Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment; obtaining payment, evaluating the quality or services provided and any administrative operations related to treatment or payment. 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 Fuqua Physical Therapy will consider requests for restriction 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 Fuqua Physical Therapy Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patients Name (printed): _____

Patients Signature: _____

Date: _____

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INSURANCE ASSIGNMENT OF BENEFITS

PATIENTS NAME: _____

ACCOUNT #: _____

I HEREBY INSTRUCT AND DIRECT _____ INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO:

FUQUA PHYSICAL THERAPY
6560 GREENBACK LANE
CITRUS HEIGHTS, CA 95621

FOR PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

PLEASE NOTE: AS A COURTESY TO YOU, WE CALL TO VERIFY BENEFITS PRIOR TO TREATMENT BUT IT IS NOT A GUARANTEE OF PAYMENT UNTIL CLAIM IS RECEIVED AND PROCESSED.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

PRINTED NAME OF CLAIMANT: _____

SIGNATURE OF CLAIMANT: _____

SIGNATURE OF POLICYHOLDER: _____

DATE: _____

INSURED'S I.D. #: _____

EMPLOYER: _____

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PATIENT CANCELLATION AND NO-SHOW POLICY

Your scheduled appointment is a specific time when your therapist *will* spend time with you. It is extremely important to be on time. If you are unable to attend, you must notify the clinic in advance of your appointment time and reschedule to make up the missed appointment. Failure to attend your session may hinder your recovery process as well as disrupt the schedule of your therapist.

Cancellation or failure to attend three consecutive appointments will result in your being discontinued from the Physical/Occupational Therapy program. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance company

In the event you are covered by workers' compensation and fail to keep your appointments as were recommended by your physician, the appropriate parties will be notified of your absence in writing. Each cancelled or no show appointment will also be noted in your Chart. Typically, the notification will be to your physician and insurance company. Please understand that failure, to actively participate in your rehabilitation program may result in the impression that you are disinterested in recovery or are better and able to return to work. This may have a negative effect on your workers' compensation coverage.

Thank you for your attention to this matter.

Patients Name (printed): _____

Patients Signature: _____

Date: _____