RANCHO WELLNESS CENTER

*Physical, Occupational & Speech Therapy*

**Dear New Patient,**

Thank you for choosing **RANCHO WELLNESS CENTER** for your physical, occupational and speech therapy needs. We know that you have many choices and we appreciate your confidence in us.

To make the most of your physical, occupational and speech therapy experience, we have provided you with all the information you will need to make your time with us the best it can be. Please take the time to read **all** of our policies and fill out the following form(s) completely **prior** to your scheduled appointment. *You are responsible for knowing all of the information in the policy pages.*

On the day of your appointment, please bring the following:

- Completed form(s)
- Insurance Card
- Prescription for physical, and or occupational, and or speech therapy services needed
- Free flowing clothing that will allow you to move easily

Arriving 10 minutes early will give you the time necessary to complete the process of admission and be ready for your appointment.

Thank you for your cooperation to make your experience with us the best that it can be.

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# PATIENT INFORMATION

Date: _____ Home Phone: _____

Patient Name: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Sex: M/F Social Security #: _____

Employer: _____ Phone#: _____

Emergency contact: _____ Relationship: _____ Phone#: _____

Referred by: ☐ Friend ☐ Relative ☐ MD ☐ Other Name: _____

Would you like to receive information about our facility via E-mail? _____Yes _____No

E-mail Address: _____

## INSURANCE INFORMATION

Insured's Name: _____ ID#: _____

Insured's Employer: _____ Group#: _____

Insurance Co. Name: _____ Phone#: _____

Claims Address: _____

Relationship to Insured: Self Spouse Child Other

Condition related to: Illness Employment Auto Other

## WORKMAN COMPENSATION INFORMATION

Date of Injury: _____ Claim#: _____

Adjuster's Name: _____ Phone#: _____

Referring Physician: _____ Family Physician: _____

SIGNATURE OF INSURED/PARENT/GUARDIAN _____

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# MEDICAL HISTORY INFORMATION

Have you ever had previous treatment for the diagnosis that we are going to be treating you for? (Physical Therapy, Home Health, Chiropractic, Pain Management)

Yes_____ No_____

If yes, where did you receive treatment and how many visits were you treat for?

_____

_____

**Please Check All That Apply**

Diabetes: _____

High Blood Pressure: _____

Heart Disease: _____

Heart Attack: _____

Pacemaker: _____

Seizures: _____

Metal Implants: _____

Kidney Problems: _____

Hernia: _____

Nervous Disorders: _____

Previous Surgeries[: _____

Allergies to Heat or Ice: _____

Others Allergies: _____

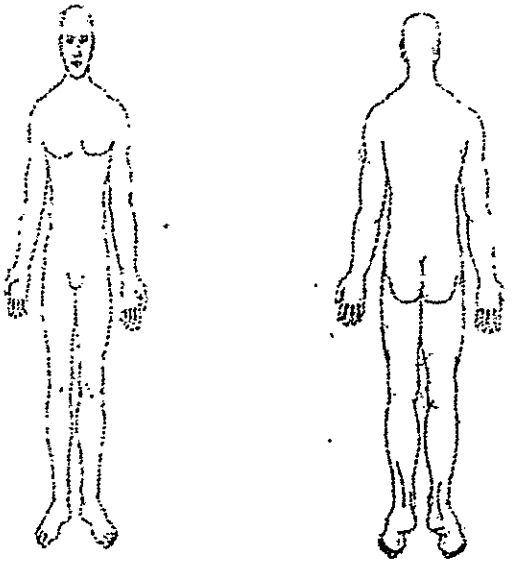
Migraines: _____

Cancer: _____

Currently Pregnant: _____

Other: _____

**On the diagram below please mark the areas of pain**



If yes to any of the above items, please give approximate dates:_____

Are you presently taking any medication? Yes_____ No_____

If yes, please list all medication and conditions you are taking them for:

_____

_____

I agree to above information is found to be true and correct.

Patient / Guardian Signature: _____ Date:_____

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Dear Patient:

Effective January 1, 2012, a financial limitation (therapy cap) was placed on outpatient rehabilitation services by Medicare beneficiaries. These limits apply to outpatients Part B, therapy services include:

- Physical Therapy – Including outpatient speech-language pathology: combines annual limit for 2024 is $2,330.-
- Occupational Therapy – Annual limit for 2024 is $2,330.-

Continuation of treatment after cap is met will mean either you:

1. Seek Physical or Occupational therapy from outpatient hospital settings.
2. Ask for exemption from Medicare backed by documentation of medical necessity and other supporting documentation.
3. Cash pay treatment

DEDUCTIBLE: Medicare has a yearly deductible of $140.

CO-PAY: Medicare covers 80% of each visit. As of May 1, 2010, Medicare patients will have a co-pay of $20.00 per visit. With a secondary or supplemental insurance, that co-pay will be $10.00

We will be happy to work with you so that you may continue receive the treatment you and your doctor have requested. If you have any question please do not hesitate to ask

I have read and understand the above.

_____ _____

Patient Name Date

**IMPORTANT: HAVE YOU HAD HOME HEALTH IN THE LAST 12 MONTHS? YES____NO____**

**WHEN:_____WHERE:_____**

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## PATIENT AGREEMENT

I hereby authorize payment directly to **RANCHO WELLNESS CENTER** from my insurance carrier. I agree to pay for any and all services that I receive from **RANCHO WELLNESS CENTER** in the event that my insurance carrier denies payment for any reason.

This office will file a claim on my behalf, but upon denial I will pay upon notification from this office. Failure to pay in 45 days of the first statement may result in collection activity or legal action.

In the event that I do not pay for services rendered when due, I agree to be responsible for any and all collection costs including, but not limited to legal costs.

SIGNATURE OF INSURED/PARENT/GUARDIAN_____

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## CONSENT TO TREAT

I will be informed of the treatment and care which has been prescribed by my physician(s) and will be provided by Rancho Wellness Center.

I understand that as a patient I am under the care and control of my physician(s) and that **RANCHO WELLNESS CENTER** is not liable for any act or omission when providing treatment in accordance with my physician(s) instructions.

I acknowledge that pursuant to Title VI of the civil rights Act of 1964,Section 504 if the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, **RANCHO WELLNESS CENTER** does not discriminate in the provision of services on the basis of race, color, national origin, disability or age.

By signing this agreement, I consent to have **RANCHO WELLNESS CENTER** provide the treatment and care prescribed by my physician; I understand this consent may be revoked by me at any time.

## STATEMENT

I, _____ am aware of my diagnosis as given by my physician, and am aware of the rehabilitation potential as anticipated and explained to me by my Physical Therapist.

Patient/Guardian signature: _____

Date: _____

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## CONSENT TO RELEASE MEDICAL RECODS

I, _____, hereby authorize **RANCHO WELLNESS CENTER** to release in whole or portions of my medical records, including but limited to, insurance companies, health care providers, worker's compensation carriers, health care administration and/or its intermediaries.

Signature of patient/guardian: _____

Date: _____

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## NOTICE OF PRIVACY PRACTICE

I was supplied with **RANCHO WELLNESS CENTERS** "Notice of Privacy Practices", I have read and understand its contents. Furthermore, I understand I am entitled to a copy of the original document, which I can request at any time.

Date_____

Name_____

Signature_____

I was supplied with a copy of **RANCHO WELLNESS CENTERS** policies. I have read and understand its contents and I agree to abide by the policies and guidelines that have been provided.

Date_____

Name_____

Signature_____

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# 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.

## Rancho Wellness Center Legal Duty

Rancho Wellness center, Inc is required by law to protect the privacy of your personal health information, to provide this notice about our information practices and to follow the information practices that are described herein.

## USES AND DISCLOSURES OF HEALTH INFORMATION

Rancho Wellness Center, Inc. uses your personal information primarily for treatment; obtaining for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Rancho Wellness Center, Inc. may use your personal health information for: **1. Treatment**- sending reports to your doctor, reminding you of appointments, or information about treatment alternatives or other health related benefits that could be of interest to you. **2. For Payment**- sending chart notes, diagnosis, and reports to your insurance company. **3. For Healthcare Operations**- use for quality assurance purposes.

Rancho Wellness Center, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information required by law.

In any other situation, Rancho Wellness Center's policy is to obtain your 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, in writing, to stop future disclosures at any time.

Rancho Wellness Center, Inc. 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 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.

## PATIENT'S 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 list 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 do 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. Rancho Wellness Center, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

## CONCERNS AND COMPLAINS

If you are concerned that Rancho Wellness Center, Inc. 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 Rancho Wellness Center, Inc. health information practices or if you have a complaint, please contact the following person:

RANCHO WELLNESS CENTER

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## RANCHO WELLNESS CENTER POLICY

We are pleased that you have chosen **RANCHO WELLNESS CENTER** for your physical, occupational and speech therapy needs. You will find that we provide individualized patient care in a professional and warm environment. Each and every one of our staff members is uniquely qualified to help you move from the rehabilitation of your injury or disability to a full healthy lifestyle.

To better serve you, please observe the following policies so that we at **RANCHO WELLNESS CENTER** can provide you with the best quality services:

- Schedule your appointments ahead of time to ensure you get a time that works well in your day.
- Be on time.
- Cell phones should be placed on silent or vibrate and put in a pocket or purse.
- Adhere to the recommended number of treatments and to your program: -it is vital that you complete the prescribed number of treatments for your therapy. This is an essential component of your progress. – Because we care about you, we realize that it would be a disservice to you if we did not emphasize the importance of your commitment to the care you need to receive.
- Clothing: be prepared to exercise with loose fitting, comfortable clothing.
- Be considerate of our therapist time and keep your scheduled appointment:
    - We, at **RANCHO WELLNESS CENTER** want to provide the best for our patients and attending scheduled appointments is a necessary part of the treatment process.
    - A 24 hours notice is required for all cancellations and rescheduled appointments.
    - We reserve the right to charge a $25 fee for a cancellation or no show within 24 hours
    - We will do everything in our power to enable you to reschedule your appointments to fit your needs.
    - Patients who are habitually late, or who fail to call and cancel missed appointments will lose the opportunity to schedule in advance and will only schedule 24 hours or less in advance.
- Children with appointment only.
- Patient privacy regulation prohibits visitors or companions in the area of patients' care.

These are policies that will help us serve you better and enable us to maintain our excellence on the level of care and services. Thank you for your cooperation.

**RANCHO WELLNESS CENTER**