2063 San Elijo Avenue
Cardiff by the Sea, CA. 92007
Phone 760.692.4735
Fax 760.635.3556

Patient Information Form

(Please present your insurance card for copying)

Patient Name: ____
Age: __________
Sex: __________
Address:____
____
Email Address:
____

Home Phone: ________________________________
Cell Phone: __________________________________
Social Security #: _____________________________
Date of Birth: ________________________________

Employer: __________________________________
Work Phone: ________________________________

Referring MD: ____________________________
Primary Care MD: ___________________________

Financial Party: (if other than patient)
____

Relationship: _______________________ SS#: ____________________________
DOB: _______________
Phone Number:____

Emergency Contact: _____________________________
Relationship: __________________________________
Phone: _______________________________________

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Patient Medical History

Name: ____
Date: __________________

Age: _______________ Weight: _________________ Height: _______________
Sex: M F

Reason for Therapy (traumatic or gradual onset):
____

Date of Onset: _________________
Surgical Procedure and Date: ___________________________

Have you been diagnosed with any of the following conditions?

Cancer	yes	no
Diabetes	yes	no
High Blood Pressure	yes	no
Heart Disease	yes	no
Angina/Chest Pain	yes	no
Deep Venous Thrombosis	yes	no
Stroke/TIA	yes	no
Osteoporosis	yes	no
Osteoarthritis	yes	no
Rheumatoid Arthritis	yes	no
HIV	yes	no

Other
____

Do you have a history of?

Allergies/Asthma	yes	no
Headaches	yes	no
Pacemaker	yes	no
Infection	yes	no
Falling	yes	no

# of falls in the last
year____

Patient Medical History Continued

Are you currently?		
Pregnant	yes	no
Depressed	yes	no
Under Stress	yes	no

Have you recently experienced?		
A change in your health	yes	no
Nausea/Vomiting	yes	no
Fever/Chills/Sweats	yes	no
Unexplained weight change	yes	no
Numbness/Tingling	yes	no
Difficulty swallowing	yes	no
Changes in bowel or bladder Function	yes	no
Shortness of breath	yes	no
Dizziness	yes	no
Unexplained night pain	yes	no
Unexplained weakness Or fatigue	yes	no

Do you have difficulty with?		
Hearing	yes	no
Vision	yes	no
Speech	yes	no

Health-Related Habits

Do you drink alcoholic beverages? Yes no

#/ week ______________________

Do you smoke tobacco yes no

packs/week____x____years

Do you drink Caffeine yes no

cans/ day__________________

Have you had any of the following tests/treatments? Please Check

_______ MRI
_______ X-ray
_______ CT scan
_______ EMG
_______ Cortisone injections

Please list all medications (over-the-counter and prescribed):

____
____
____
____

I affirm that the above information is accurate and true.
Patient Signature: ____
Date:__________________________

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PHYSICAL THERAPY

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Office Payment Policy

It is the policy of Blue Water Physical Therapy that payment is due at the time of service. We require all patients to pay their deductible, co-pay and/or co-insurance payment at the beginning of each visit. The average cost of a physical therapy visit is $100, and we will be utilizing this amount to calculate your co-insurance payment. For example, if you have an 80/20, you are responsible for $20 each visit. At the conclusion of your therapy you may be billed for any outstanding balances. If there is a positive balance or credit, you will be provided a refund promptly.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with many insurance plans, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. **Please initial our payment method and sign below that you have read, understand, and agree with all of the information on this page.**

_______ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurances are due at the time of service.** Should your insurance deny coverage, you will be billed for the outstanding amount.

_______ 2. MEDICARE: Blue Water Physical Therapy is a certified Medicare provider. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

Is Medicare the patient's primary insurance? Yes / No **SECONDARY MEDICARE INSURANCE PROVIDER: ______________________________________**

Office Payment Policy Continued

_______ **3. CASH PAYMENT:** A discount is given for treatment packages purchased in advance. PKG. Purchase:
10 visits _____________ Date ________________
20 visits ______________ Date _______________

_______ **4. OTHER:** Please list the other type of payment:
____

_______ **5. LIENS AND THIRD PARTY PAYMENTS:** Liens and third party payments are accepted upon approval by our manager only. All visits require a $50 co-pay due at the time of service.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to Blue Water Physical Therapy. I understand that I am responsible for payment of services rendered by Blue Water Physical Therapy. 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 request that payment of authorized Medicare benefits be made either to me or on my behalf to Blue Water Physical Therapy for any service furnished to me by Blue Water Physical Therapy. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

I have reviewed this office payment policy and discussed it with the office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Patient Signature:
____

Guardian Signature (if patient is < 18 years old):
____

Date: _________________________________

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Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed. Please review it carefully.

* Blue Water 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 we describe herein.

* Blue Water Physical Therapy uses your personal health information for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide.

* Blue Water Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, auditing purposes and public health statistical purposes. We also provide information when required by law. In any other situation, our 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 to stop future disclosures at any time.

* Blue Water Physical Therapy may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room.

* You have the right to review or obtain a copy of your personal health information at any time. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administration purposes except when specifically authorized by you, when required by law or in emergency circumstances.

Please retain this copy for your records.

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Acknowledgement of Privacy Practices

I have read and fully understand the Blue Water Physical Therapy Notice of Privacy Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted. I understand that I have the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: ____

Signature: ____

Date:
____

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Cancellation Policy and Consent to Treat

We at Blue Water Physical Therapy strive to provide our patients with the utmost professionalism and excellence of service. Your adherence to the prescribed number of treatments is a vital component of your progress. We request that you keep all of your appointments, with the exception of serious emergencies. If you need to re-schedule an appointment we require 24 hours notice.

In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge a **$ 50.00** fee.

By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described.

I grant permission for the staff of Blue Water Physical Therapy to perform the procedures as prescribed by my physician including evaluation and treatment. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure at any time.

If I become ill while undergoing treatment, I give permission to the staff to administer treatment, which they consider necessary to my well-being.

My signature below indicates that I understand and give consent to be treated as explained above.

Patient Signature: ____
Date: ________________
Guardian's Signature (if patient is < 18 years old):
____

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FREQUENTLY ASKED QUESTIONS ABOUT OUR CREDIT CARD POLICIES:

Why is Blue Water requiring a credit card agreement from patients?
This practice will improve efficiency for everyone and lower total costs of providing service to our patients. It will also allow us to focus our energies on providing care, rather than patient billing.

When will my credit card be charged?
As a courtesy to our patients, we submit claims to their insurance provider within a few days of providing the patient service. Insurance companies typically settle claims within 2-8 weeks after service was provided. Once a claim is adjudicated, your card will be charged for your portion.

How will I know how much the charge will be?
Insurance typically sends an Explanation of Benefits (EOB) to both the patient and the provider after claims have been settled. The EOB explains the contracted fees agreed between our office and the insurance company. The EOB also shows whether any of the agreed upon fee must be paid by the patient in the form of a co-pay, co-insurance or deductible. At that time, any balance is due in full.

What if I do not agree with the patient portion as specified by my insurance provider?
As the customer of the insurance company, patients can exercise procedures with their insurance provider for handling disputes as to whether the insurance provider or the patient is responsible for a particular fee. These procedures are typically regulated by state regulations. Our office's position is that the patient is ultimately responsible for the cost of the service provided, up to the amount allowed by an insurance plan that our office accepts. We do not discuss any dispute with regards to what portion of payment is the patient's responsibility versus the insurance company's responsibility. Nonetheless, we will provide our expertise to our patients, as a resource, to help facilitate understanding of what their insurance company communicates to them about their contract.

What if I still do not agree with the charge applied to my card?
Our office's billing staff will review each patient's situation before applying a charge. In the event of any question or issue, please do not hesitate to contact our billing office or office manager and we will work to resolve it as soon as possible. As a last resort, our patients should rest assured that credit card issuers typically have procedures for a cardholder to dispute a charge applied by any merchant. Credit card companies can typically suspend or reverse charges if they determine the charge was not appropriate.

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To our patients,

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time of check in. That information will be held securely until your insurances have paid their portion and notified both you and us how much, if any, is your portion. At that time, any remaining balance owed by you will be charged to your credit card and it will be presented on your credit card statement as "Blue Water Physical Therapy".

This will be an advantage to you, because you will no longer have to write out and mail us a check. It will be an advantage to us as well, because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep cost of health care down.

Much like when you check into a hotel or rent a car you are asked for a credit card, which is imprinted and later used to pay your bill.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,
Blue Water Physical Therapy

I authorize Blue Water Physical Therapy to charge outstanding patient portion balances for me to the following credit card:

Visa MasterCard American Express
Account number____
Expiration Date_______ Signature Code_______ Billing Zip Code_________

Signature_______________________ Date___________________
Full Name on Credit Card (please print) ____

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Patient Communication Consent

Our office offers patient communication by email, text messaging and phone call. This form provides the risks of emails, guidelines for email communication and how we use email communication. It will also be used to document your consent for communication with you by email.

Communication by email has a number of risks, which include the following:

* Can be circulated, forwarded and stored in paper and electronic files

* Backup copies of emails may exist even if the file has been deleted

* Can be received by unintended recipients

* Can be intercepted, altered, forwarded or used without authorization or detection

* Senders can easily type the wrong email address

* Can be used to introduce viruses into the computer system

How we will use email:

We will utilize email correspondence to established patients who are 18 years or older or the legal representative of established patients. We use email to communicate only about non- sensitive and non-urgent issues. You have the same right of access to emails as you do to your medical record. Your email message may be forwarded to another office staff member as necessary for appropriate handling. We will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication. Thus, you must consent to the use of email for patient information. You are responsible for informing us of any types of information you do not want to be sent by email. Please refer to our Notice of Privacy Practices.

How you should use email:

You should avoid using an employer's or other third party's computer. You should inform Blue Water Physical Therapy of any changes to your email address. Please avoid placing any personal or confidential information in the subject line of the email. You shall withdraw consent only by email or written communication to Blue Water Physical Therapy. Should you need immediate assistance, do not rely on email.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL OR TEXT MESSAGES, CALL 911.

Please initial here to confirm you have read and understood the above:

Initials ________

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If you would like to communicate with Blue Water Physical Therapy by email:

I have elected to communicate with Blue Water Physical Therapy by email.

I understand the risk of communication by email, in particular the privacy risks explained in this form. I understand that Blue Water Physical Therapy cannot guarantee the security and confidentiality of email communication. I understand that I may also communicate with Blue Water Physical Therapy by telephone or during a scheduled appointment. I understand that I am responsible for informing Blue Water Physical Therapy of any types of information I do not want sent by email. I understand that I may revoke this consent at any time by advising Blue Water Physical Therapy in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Print name _______________________

Email address ______________________________

Signature ________________________ Date __________________

If you would NOT like to communicate with us by email:
Print name_______________________

Signature _______________________ Date___________________

If you would like to communicate with Blue Water Physical Therapy through text messaging:

I have elected to communicate with Blue Water Physical Therapy through text messaging.

I understand the risk of communication by text message, in particular the privacy risks explained in this form. I understand that Blue Water Physical Therapy cannot guarantee

the security and confidentiality of text message communication. I understand that I may also communicate with Blue Water Physical Therapy by telephone or during a scheduled appointment. I understand that I am responsible for informing Blue Water Physical Therapy of any types of information I do not want sent by text message. I understand that I may revoke this consent at any time by advising Blue Water Physical Therapy in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Print name ________________________

Email address _______________________________

Signature _________________________ Date ___________________