WELCOME TO McCARTHY PHYSICAL THERAPY

Notice of Information Practices

INSURANCE: Your insurance is a contract between you and your insurance carrier. We will gladly bill your insurance as a *courtesy.* However, if your insurance denies any portion of an authorized claim, you are responsible for all balances.

Insurance coverage is different for each person. It is your responsibility to check your policy for covered services, co-pay, co-insurance amounts, and if pre-authorization is required. This should be done prior to attending the first visit. If a patient attends an appointment prior to verification/authorization, and the visit is not covered by insurance, the cost of that visit will be the patient's responsibility. Please be sure to notify our office immediately is there are any changes in your insurance coverage.

MEDICARE: We are a Medicare provider and will accept assignment from Medicare. There is an annual cap for outpatient physical therapy. Medicare covers physical therapy and 80% of their accepted fee schedule. The patient is responsible for the remaining 20%. If there is a secondary policy to Medicare, please provide the secondary insurance information. Once the Medicare cap has been met, the patient is responsible for all the future charges.

WORKMAN'S COMPENSATION: It is imperative to supply us with a billing address for the industrial carrier, name and telephone number of your adjustor, and you claim number to ensure proper billing, you can obtain this information from your employer. We have a three strikes policy. If you miss three appointments, you will be discharged from treatment and your doctor and insurance adjustor will be notified.

APPOINTMENTS: Patients are seen by appointment only. Scheduling is done first come, first served basis. We recommend scheduling your appointments in weekly intervals. If you need to cancel an appointment, we require at least 24 hours notice. A phone call is required to avoid a charge for a missed appointment. The charge for a missed appointment will be billed to the patient.

DOCTOR APPOINTMENTS: A referral/prescription for physical therapy, written by your doctor, is required by all insurances before payment will be considered. It is your responsibility that a current referral/prescription in our file for billing purposes. Any charges denied by insurance due to lack of a current referral/prescription will be the patient's responsibility. Be sure to keep your follow-up appointments with your doctor. Please inform your therapist of all return doctor visits so we can send them the appropriate progress report. It is during your follow-up appointment and by communication with your therapist that your doctor will determine if additional therapy is appropriate.

PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS

Signature:____ Date:________________________

Signature:____ Date:________________________

Signature:____ Date:________________________

114 N. Sunrise Ave., Suite B-1 • Roseville, CA 95661 • (916)789-1384 • Fax (916)782-7112

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand McCarthy Physical Therapy Notice of Information Practices. I understand that McCarthy Physical Therapy, may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating that quality of 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 McCarthy 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 McCarthy 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.

____

Patient Name:

____

Signature:

____

Date:

____

Signature:

____

Date:

PATIENT INFORMATION

Name:____
Address:_________________________________ City: ___________________State:___________Zip: ______________
Contact Number:_______________________________Email Address:____
Emergency Contact(relationship):______________________________________Number:_________________________
Birth Date: ____SSN:__________-__________-____________Sex: M F
Employer:____
Address:_________________________________ City: ___________________State:___________Zip: ______________
Work Number:____

INSURANCE INFORMATION

Guarantor Name & Relationship:____Guarantor DOB:________________
Insurance Name:____ ID#: ________________________Group #:_____________
Address:____ City: ____
State:___________Zip: ______________Phone Number:____

SECONDARY INFORMATION

Guarantor Name & Relationship:____Date of Birth:_________________
Insurance Name:____ ID#: ________________________Group #:_____________
Address:____ City: ____
State:___________Zip: ______________Phone Number:____

Injury at Work? YES NO Date of Injury:_____________________Motor Vehicle Accident? YES NO Date of Loss:_________
Employer at time of Injury:____
Referring Doctor:____
Diagnosis/Body Part:____

AUTHORIZATION AND ASSIGNMENT

I, the undersigned, do hereby agree and give my consent for McCarthy Physical Therapy & Sports Medicine, Inc., to furnish physical therapy evaluation and treatment considered necessary and proper in diagnosing or treating the physical condition.
I hereby assign all physical therapy benefits to McCarthy Physical Therapy & Sports Medicine, Inc. I understand that I am financially responsible for all charges. Cancellations or mussed appointments with less than 24 hours advance notice to your office are subject to a $25.00 fee. I hereby authorize release of all clinical and payment information necessary to secure payment. A photocopy shall be considered valid.

Print Name: ____
Signature:____Date:____________________

Y	N	
□	□	Osteoporosis
□	□	Diabetes
□	□	Hypertension (High Blood Pressure)
□	□	Heart Disease
□	□	Cancer or Tumors
□	□	Lung Problems
□	□	Stomach Problems
□	□	Kidney or Liver Problems
□	□	Arthritis or other Joint Problems
□	□	Seizures or Nervous Disorders
□	□	Allergies
□	□	Dermatitis or any other Skin Problems
□	□	Eye Problems
□	□	Hernias
□	□	Unusual/Frequent Headaches
□	□	Are there any other health problems not mentioned above? If so please describe:

Y	N	
□	□	Are you pregnant?
□	□	Do you have any implants (i.e. joint replacements or pacemakers)?
□	□	Are you awakened at night?
□	□	Do you ever have uncontrolled leakage of urine, gas or feces?
□	□	Have you ever taken medication longer than a few weeks?
□	□	Are you currently taking any medications?
□	□	Have you ever been hospitalized?
□	□	Have you ever had surgery?
□	□	Have you ever been placed in a splint, cast, ace wrap or sling?
□	□	Have you ever had to use crutches, canes, a walker or wheelchair?
□	□	Do you use shoe lifts, braces, corsets, or supports?
□	□	Are you currently treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, etc.?

MEDICATIONS

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Do you consider your health to be: □ Excellent, □ Good, □ Fair, □ Poor

Date of Last Physical:______________Physician:__________________________Current Physician:______________

Reason for Today's Visit: __________________________________ Who Referred you to us? __________________

Patient Signature: ____ Date: _____________________________