Sacramento Spine & Physical Therapy

www.sacramentospine.com sacspine@msn.com

PAYMENT INFORMATION and AGREEMENT

Welcome to Sacramento Spine & Physical Therapy (SSPT)! If you have questions about your financial obligations, please let us know immediately.

- **Third Party Payer-Auto/Liens and Legal cases**
  1. Whether or not you have an attorney, we need you to sign a lien to cover all outstanding charges not covered by the policy medical payments. You are ultimately responsible for all charges.
  2. In the event that Medical Payment coverage is exhausted, you are still responsible for all outstanding charges thereafter. You are advised to monitor the medpay status. Please ask and we will go over this with you.***Initial ____**
- **Private Insurance and Medicare *Initial ____**
  1. Are you currently having home health services? ____Yes ____No
  2. I authorize SSPT to bill my insurance on my behalf and agree to assign any insurance benefits to go directly to SSPT for services rendered. I am ultimately responsible for the charges if my insurance does not cover the care, unless contracted rates apply and/or the charges are disallowed.
  3. If a dispute arises between my insurance company and me, I may be asked to pay the outstanding balance and then pursue reimbursement from my insurance company thereafter.
  4. I agree to pay any portion of the bill assigned as a patient portion by my insurance each month,
  5. SSPT is ___IN network ___ OUT of network with your insurance. (Check one)
  6. Co-Pay _____ Deductible _____ Portion of Deductible met_____ This information is what has been obtained by your insurance carrier and is assumed to be accurate but it is ultimately the patient's responsibility to verify.
- **<u>All</u> patients**
  1. Sac Spine will wait up to 90 days after the date of service for any insurance covered payments that may be due. After 90 days, you may be asked to make arrangements to pay the balance due to SSPT and pursue reimbursement from the covering insurance company thereafter or you may be allowed to assign the balance to an attorney lien if that applies.
  2. If charges remain unpaid after 90 days, you may be charged an administrative service charge of 1 ½% per month (APR 18%) on unpaid balances after 90 days.
  3. I understand if I have an unpaid balance to SSPT and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.
  4. In order for SSPT or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that SSPT and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. ***Initial ____**
- **All Patients**
  1. Appointment cancellations require at least 12 hours notice, or you will incur a $20.00 fee. If your coverage is Medi-cal and miss an appointment without adequate notice you will be discharged. ***Initial _____***
  2. We do not require a physician referral in order to provide your rehab. However, many insurance companies will not pay for services without a physician referral.

I have understood and agree to the above payment contract. A copy is as valid as the original.

Date:_____ Signature of responsible party:_____

<u>1650 Leadhill Boulevard, #300, Roseville, CA 95661-Phone 916-677-1210-fax 916-677-1214</u>
700 Oak Ave Pkwy, Folsom, CA 95630-Phone 916-932-1210-fax 916-932-1205

Sacramento Spine & Physical Therapy

www.sacramentospine.com sacspine@msn.com

RELEASE OF RECORDS

I authorize Sacramento Spine and Physical Therapy to:

1. Release any and all medical records, reports, history, diagnosis, treatment, radiology reports, and all other records of any kind or nature, for services rendered in connection with my care and treatment to insurance or medical personnel involved with this care. (Expiration if desired:_____)
2. If it is necessary to obtain documents from my Sacramento Spine and Physical Therapy File, I consent to the acceptance of an email; hereof in lieu of the original documents.
3. Obtain copies of my medical records in connection with care at their facility.

Patient's Name:_____ SSN or DL#_____

Patient's Signature:_____ Date:_____

E-mail address (no cursive please): _____

Mailing address: _____

Use of Roseville Health & Wellness Center Inc. (RHWC) and/or California Family Fitness (CFF) during physical therapy

As a participant with Sacramento Spine & Physical Therapy (SSPT), I understand that the Roseville Health & Wellness Center Inc, (RHWC) and/or California Family Fitness (CFF) will not be responsible for any loss, claim, or damage incurred with respect to any negligence of SSPT. I understand that SSPT is fully responsible for my care and I may request their general and professional liability insurance face sheets to reference coverage. In the event I should sustain any injuries or damages while under the care of SSPT, I hereby agree to present any and all such claims to SSPT. This is not intended to waive any of my legal rights; however, it is intended to make SSPT the primary party liable for claims mentioned herein. I hereby assume the risks associated with lost, stolen, or damaged automobile, personal property, money, or other valuables brought to the facility or left on the premises, including the locker room.

Patient's Signature: _____ Date:_____

EMERGENCY CONTACT: _____

PHONE: _____

SACRAMENTO SPINE & PHYSICAL THERAPY

Privacy Practices

The recent HIPPA regulations for healthcare mandate that all medical providers must disclose the privacy practices in place regarding the handling and use of patients' Protected Health Information (PHI) as well as the patients' rights.

Your health information is typically a record of each visit you make that contains symptoms, medical history, examinations, diagnoses, treatments, and plans for future care. This is used as a:

- means of communicating among health professionals contributing to your care
- legal document of the care you receive
- means in which you or a 3rd party payer can verify services received were appropriately billed
- tool to assess and improve the care we provide

Your health information rights related to your medical and billing records are as follows:
Authorization to use your health information. Before we use or disclose your PHI, other than described below, we will obtain your written authorization, which you may revoke at any time.
Access to your health information. You may request, in writing, a copy of your health information that is in your medical and/or billing record. There may be a fee for this.
Amend your health information. If you believe the information we have about you is incorrect or incomplete, you may request in writing that we correct or add information.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures to govern the behavior of our workforce and business associates, and provide this notice about our privacy practices and abide by it.

We reserve the right to change these policies and procedures. When we make a significant change, we will also change this notice. The new notice will posted at the front desk and on our website.

Except for purposes related to your treatment, or to collect payment for our services, or to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your PHI without your authorization.

We may use your information to contact you to provide appointment reminders.

We will use your information to facilitate your medical treatment.

We will use your information to collect payment for health care services that we provide.

For more information or to report a problem

If you have questions would like additional information, or want to request the most current copy of this notice, please contact Travis Smith at 916-932-1210.

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact Travis Smith. You may also send a written complaint to the US Department of Health and Human Services at:

200 Independence Ave SW, Washington DC 20201.

Sacramento Spine will ensure that the care you receive at our facility will in no way be impacted if you file a complaint.

I am comfortable with the open clinic environment and the privacy of curtains for my care; should this change, I will let the manager know ASAP. ***Initials** _____

I have received and read a copy of the Privacy Practices for Sacramento Spine and Physical Therapy document.

Patient Signature_____ **Date**_____

Sacramento Spine and Physical Therapy

Patient Name _____ ***Date of Birth and Age:*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

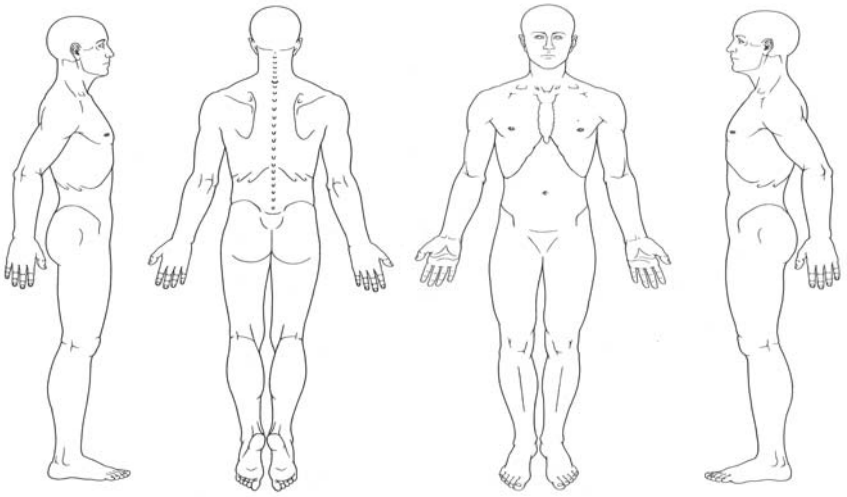
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints* ① ② *Mild, forgotten with activity* ③ ④ *Moderate, interferes with activity* ⑤ ⑥ *Limiting, prevents full activity* ⑦ ⑧ *Intense, preoccupied with seeking relief* ⑨ ⑩ *Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply)**:***

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Sacramento Spine and Physical Therapy - Intake Page 2:

Patient Name _____ ***Date of Birth and Age:*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	*Present*	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	*Present*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Pelvic organ prolapse
○	○	Pelvic surgery
○	○	Pregnancy # _____
○	○	

Other Health Problems/Issues

○	○
○	○
○	○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

Prescription, over-the-counter, nutritional or herbal supplementation; continue on reverse if needed:

Name	*Dosage*	*Frequency*	*Route (oral, topical, etc.)*

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

I attest that this information is complete and accurate to the best of my ability:

Patient Signature _____ ***Date*** _____

General Information For Patients
Sacramento Spine and Physical Therapy

➢ 1650 Leadhill Blvd. Ste. 300, Roseville, CA 95661 (916) 677-1210

Over the years we have found certain actions that patients can take which will generally help them in overcoming their presenting complaints. If something listed here increases your symptoms or of which you have questions, please stop the activity until you consult with your therapist or M.D.

1. Eliminate or decrease the frequency of activities which cause pain. This just perpetrates the inflammatory and degenerative process. Ask your therapist to provide you with different strategies to perform those activities.

2. If you get a delayed onset of pain, play Sherlock Holmes and discover what activity you are performing that causes your pain. Ask your P.T. to provide you with different movement or postural suggestions to help decrease the irritation.

3. With acute or recent injuries always apply ice, no more than 15 minutes at a time, every hour, most authorities advise.

4. Ice is also helpful with chronic or inflammatory pain, especially pain which comes on after an activity.

5. Heat helps with stiffness and achiness, but should not be used with acute symptoms as it causes swelling.

6. If you do not get increased symptoms walking you should take therapeutic walks. The ideal is twice a day to tolerance or 15 minutes. It is okay if you want to walk longer and it does not increase your symptoms.

7. To improve you must do your exercise program as prescribed by your therapist and utilize pain free and proper mechanics. This is your part of the team approach to solving your problem.

8. Many patients have found that drinking more water has helped them reduce the soreness from treatments and to assist their problem. Drink up to eight tall glasses of water a day, especially on treatment days.

9. Many MD's recommend taking vitamins during the recovery stages of a physical injury. Vitamin C, which is important in developing scar tissue has been recommended to assist the healing process. Some recommend as much as 2-3 grams if it does not cause loose stools.

10. Become aware if your pain is increased by muscle tension and stress. If you tend to hold the area of pain tightly, begin to train yourself to keep the muscles of the area relaxed. If you find this difficult, bio-feedback can often be helpful in training you to be more relaxed.