

Sacramento Spine & Physical Therapy

www.sacramentospine.com

sacspine@msn.com

PAYMENT INFORMATION and AGREEMENT

Welcome to Sacramento Spine & Physical Therapy (SSPT)! In order to allow us to provide the care you require, we need to cover the following billing and payment policies. If you have questions about your financial obligations, please let us know immediately.

- **This section only applies to Third Party Payer-Auto/Liens and Legal cases**
 1. Whether you have an attorney or not, you need 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. If you do not understand how to do this, please ask and we will go over this with you. *Initial _____
- **This section only applies to Private Insurance and Medicare *Initial _____**
 1. MEDICARE ONLY-In order to bill a patient for non-covered services, SSPT must give you an Advanced Beneficiary Notice form or we cannot bill you for any non-covered Medicare services.
 2. I authorize SSPT to bill my insurance on my behalf and agree to assign any insurance benefits otherwise payable to me 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. I understand that SSPT will not accept responsibility for collecting my insurance claim if a dispute arises between my insurance company and me. If such a dispute should arise, I agree 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 ___ N/A 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.
- **All patients listed above**
 1. Sac Spine will wait up to 90 days after the date of service for any insurance covered payments that may be due. If the insured has not paid after 90 days, you must 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.
 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. If any legal action or collections activity is taken by SSPT to collect the balance due on my account, you may be charged attorney/collection fees. *Initial _____
- **Worker's Compensation**

We must receive authorization from your insurance carrier before we can continue treatment after your evaluation. Reports of your progress and attendance may be submitted to your physician and the carrier/employer; and we may need to discuss your case with them as well.
- **All Patients**
 1. If canceling an appointment, you must provide at least 12 hours notice, failure to do so will incur a \$20.00 fee. You may be allowed to reschedule the missed appointment within the week to avoid the fee. *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. We can recommend a physician to all patients who do not have one.

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

Date: _____ **Signature of responsible party:** _____

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RELEASE OF RECORDS

I authorize Sacramento Spine and Physical Therapy to:

1. Release any and all medical records, reports, history, diagnosis, treatment, MRI 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 a photocopy; 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: _____

Patient's Signature: _____ Date: _____

E-mail 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 wave 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: _____

Sacramento Spine & Physical Therapy

Cancellation and Now Show Policy

TO ALL PATIENTS:

Sacramento Spine & Physical therapy has based its philosophy on the idea of one-n-one care for all patients. Due to our unique philosophy, we are forced to comply with a strict attendance policy to ensure that every patient we see receives only the best of care.

The following information explains our attendance policies:

1. Cancellations MUST occur 12 hours prior to a scheduled appointment.
2. Cancellations received with less than a 12-hour notice are subject to a \$20 cancellation fee.
3. Cancellation fees will be waived if the appointment is rescheduled to either later that week or the following week.
4. Patients who fail to attend a scheduled appointment will be charged a \$20 NO SHOW fee.
5. Patients who fail three appointments will be discharged from physical therapy at our clinic with a letter stating NON-COMPLIANCE sent to the attending physician, insurance companies and attorneys, if applicable.
6. Patients who fail, and are discharged, are still responsible for the \$200 fees accumulated with Sacramento Spine & Physical Therapy.
7. No show and cancellation fees are ultimately the patient's responsibility.

I have read and understand the above appointment policies.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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 be 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 _____

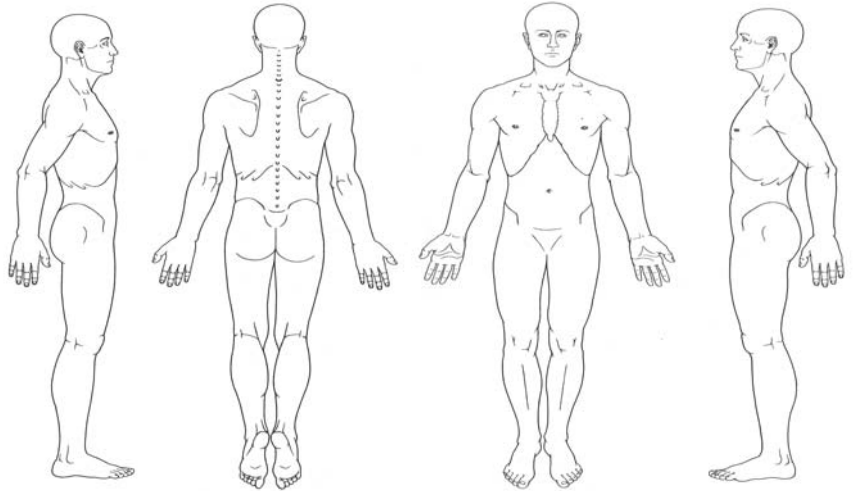
Date of Birth and Age: _____

1. When did your symptoms start: _____

Describe your symptoms and how they began: _____

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

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

- | | | | | | | | | | |
|---------------|-------------------------------|------------------------------------|----------------------------------|--|------------------------------|---|---|---|---|
| ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| No complaints | Mild, forgotten with activity | Moderate, interferes with activity | Limiting, prevents full activity | Intense, preoccupied with seeking relief | 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
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

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
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

11. What is your occupation?

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

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

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

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

- ① Reduce symptoms
- ③ Explanation of condition/treatment
- ⑤ How to prevent this from occurring again
- ② Resume/increase activity
- ④ Learn how to take care of this on my own
- 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	Past	Present	Past	Present
<input type="radio"/>	<input type="radio"/> Headaches	<input type="radio"/>	<input type="radio"/> High Blood Pressure	<input type="radio"/>	<input type="radio"/> Diabetes
<input type="radio"/>	<input type="radio"/> Neck Pain	<input type="radio"/>	<input type="radio"/> Heart Attack	<input type="radio"/>	<input type="radio"/> Excessive Thirst
<input type="radio"/>	<input type="radio"/> Upper Back Pain	<input type="radio"/>	<input type="radio"/> Chest Pains	<input type="radio"/>	<input type="radio"/> Frequent Urination
<input type="radio"/>	<input type="radio"/> Mid Back Pain	<input type="radio"/>	<input type="radio"/> Stroke	<input type="radio"/>	<input type="radio"/> Smoking/Use Tobacco Products
<input type="radio"/>	<input type="radio"/> Low Back Pain	<input type="radio"/>	<input type="radio"/> Angina	<input type="radio"/>	<input type="radio"/> Drug/Alcohol Dependence
<input type="radio"/>	<input type="radio"/> Shoulder Pain	<input type="radio"/>	<input type="radio"/> Kidney Stones	<input type="radio"/>	<input type="radio"/> Allergies
<input type="radio"/>	<input type="radio"/> Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/> Kidney Disorders	<input type="radio"/>	<input type="radio"/> Depression
<input type="radio"/>	<input type="radio"/> Wrist Pain	<input type="radio"/>	<input type="radio"/> Bladder Infection	<input type="radio"/>	<input type="radio"/> Systemic Lupus
<input type="radio"/>	<input type="radio"/> Hand Pain	<input type="radio"/>	<input type="radio"/> Painful Urination	<input type="radio"/>	<input type="radio"/> Epilepsy
<input type="radio"/>	<input type="radio"/> Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/> Loss of Bladder Control	<input type="radio"/>	<input type="radio"/> Dermatitis/Eczema/Rash
<input type="radio"/>	<input type="radio"/> Knee/Lower Leg Pain	<input type="radio"/>	<input type="radio"/> Prostate Problems	<input type="radio"/>	<input type="radio"/> HIV/AIDS
<input type="radio"/>	<input type="radio"/> Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/> Abnormal Weight Gain/Loss		
<input type="radio"/>	<input type="radio"/> Jaw Pain	<input type="radio"/>	<input type="radio"/> Loss of Appetite		
<input type="radio"/>	<input type="radio"/> Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/> Abdominal Pain		
<input type="radio"/>	<input type="radio"/> Arthritis	<input type="radio"/>	<input type="radio"/> Ulcer		
<input type="radio"/>	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/> Hepatitis		
<input type="radio"/>		<input type="radio"/>	<input type="radio"/> Liver/Gall Bladder Disorder		
<input type="radio"/>	<input type="radio"/> General Fatigue	<input type="radio"/>	<input type="radio"/> Cancer		
<input type="radio"/>	<input type="radio"/> Muscular Incoordination	<input type="radio"/>	<input type="radio"/> Tumor		
<input type="radio"/>	<input type="radio"/> Visual Disturbances	<input type="radio"/>	<input type="radio"/> Asthma		
<input type="radio"/>	<input type="radio"/> Dizziness	<input type="radio"/>	<input type="radio"/> Chronic Sinusitis		

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.