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:_____

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

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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:_____

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 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:***

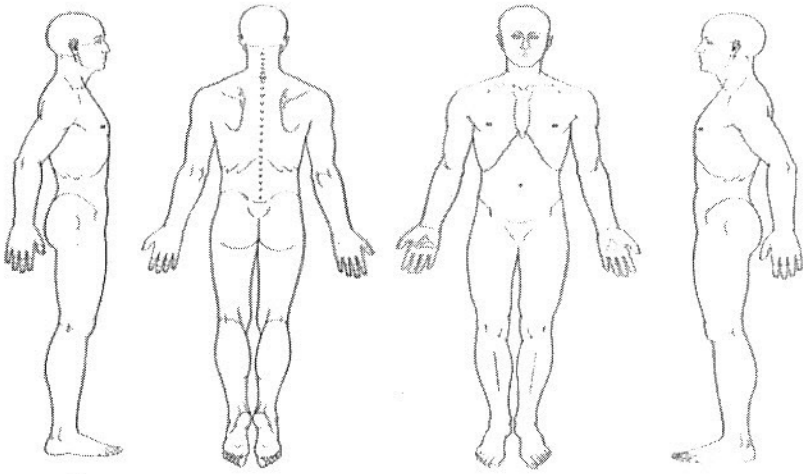
_____

_____

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	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
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.

Keeping a Record of Bowel and Bladder Function

The main purpose of a bowel diary is to document how your bowel functions. A diary can give your health care provider an excellent picture of your bowel functions, habits and patterns. At first, the diary is used as an evaluation tool. Later, it will be used to measure your progress on bowel retraining.

Please complete a bowel & bladder diary every day for 2 days and bring it with you to your appointment. Please note: you do not have to pee in a cup. You can use the restroom as you normally do. Just remember to keep track.

Instead of using a measuring device to report urination, please count the number of seconds that you have urinary flow. If the flow starts & stops, please mark a + sign to annotate that next to the total number of seconds of flow. That will help give an estimate but avoid use of a cup when in public bathroom, etc.

Your diary will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

Instructions

Column 1—Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording.

Column 2— Type and Amount of Fluid and Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3— Elimination of Urine and Bowel Movements (BM)

Record the time of day and amount of urine emptied by writing a "U" for urinate.
Record a bowel movement with a "BM".
Place a "U" or "BM", in the box at the corresponding time interval each time you empty
Also note the stool consistency using the following Bristol Stool Type Scale:

Type 1 - Separate hard lumps, like nuts (hard to pass)
Type 2 - Sausage-shaped but lumpy
Type 3 - Like a sausage but with cracks on its surface
Type 4 - Like a sausage or snake, smooth and soft
Type 5 - Soft blobs with clear-cut edges passed easily)
Type 6 - Fluffy pieces with ragged edges, a mushy stool
Type 7 - Watery, no solid pieces; entirely liquid

Column 4- Amount of Leakage / Stool Loss

Record the amount of urine lost at the time it occurred.

S- SMALL = drop or two of urine
M- MEDIUM = wet underwear
L- LARGE = wet outerwear or floor

Record the amount of stool lost at the time it occurred.

S = Small stain
P = Pea size
T = 1-2 tablespoons
C = Complete BM lost

Column 5 — Was Urge Present?
Describe the urge sensation you had as:

1- MILD = first sensation of need to go
2- MODERATE = stronger sensation or need
3- STRONG = need to get to toilet, move aside!

Column 6 - Activity with Leakage / Notes
Describe the activity associated with the leakage, i.e., coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

Comments — Special problems and new or changed medications go here. If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & FLUID intake	**Elimination U = Urinate BM = bowel movement type**	Amount of Leakage S / M / L S / P/ T/ C	Was Urge Present? 1 / 2 / 3	Activity With Leakage / Notes
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	U		3	
7:00 am	Coffee, bagel	BM type 4			
8:00 am			M		Fast walking
9:00 am	Apple	U BM	Pea sized	2	No urge control
10:00 am					
11:00 am		U		1	Key in the door
NOON	Tuna sandwich, milk, pear				
1:00 pm					
2:00 pm		U		2	
3:00 pm	Tea, cookies		S		Running water
4:00 pm					
5:00 pm					
6:00 pm	Chicken, corn pudding, salad, apple juice	U		3	
7:00 pm					
8:00 pm			S	3	
9:00 pm					
10:00 pm	To bed at 10:30	U		3	
11:00 pm					

Comments: Week before period_____ Number of pads:_____

Record of Bowel and Bladder Function

Name _____ *Date*_____

Time of Day	Type & Amount of Food & Fluid Intake	Elimination U = Urinate BM = bowel movement type	Amount of Leakage S /M /L S /P/T/ C	Was Urge Present 1/2/3	Activity With Leakage/ notes
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

Record of Bowel and Bladder Function

Name _____ *Date*_____

Time of Day	Type & Amount of Food & Fluid Intake	Elimination U = Urinate BM = bowel movement type	Amount of Leakage S /M /L S /P/T/ C	Was Urge Present 1/2/3	Activity With Leakage/ notes
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

Elder Abuse Suspicion Index

Instructions:

Questions 1-5 asked of patient. Question 6 asked by doctor within the last 12 months.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?

Yes
No
Did not answer

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?

Yes
No
Did not answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

Yes
No
Did not answer

4. Has anyone tried to force you to sign papers or to use your money against your will?

Yes
No
Did not answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

Yes
No
Did not answer

6. Doctor: Elder abuse may be associated with fundings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

Yes
No
Not Sure

Score Meaning:

Score Meaning: While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern.

AUDIT-C

Instructions:

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

1. How often do you have a drink containing alcohol?
- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?
- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

Score Meaning:

a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

In Men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.

In Women, a score of 3 or more is considered positive (same as above).

Falls Efficacy Scale

Take a bath or shower

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Reach into cabinets or closets

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Walk around the house

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of bed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Answer the door or telephone

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of a chair

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting dressed and undressed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Personal grooming (i.e. washing your face)

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting on and off of the toilet

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident
