1601 Dove Street, Suite 100, Newport Beach, CA 92660
(P) 949.274.9551 (F) 949.264.8219

[ ] Cash [ ] Insurance [ ] Medicare [ ] Personal Injury [ ] Workers Comp. [ ] Auto Accident

PATIENT INFORMATION

NAME (LAST, FIRST):		DATE: / /
STREET ADDRESS:	HOME #:	CELL #:
CITY:	STATE:	ZIP:
SSN:	SEX (CIRCLE ONE):	M F
DATE OF BIRTH: / /	AGE:	OCCUPATION:
REFERRED BY:	PCP/DOCTOR:	
DATE OF INJURY (or onset): / /	DIAGNOSIS/BODY PART:	
EMAIL ADDRESS:	WORK PHONE:	
EMERGENCY CONTACT: NAME:	PHONE #:	

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE:	NAME OF INSURANCE:
CLAIMS MAILING ADDRESS:	CLAIMS MAILING ADDRESS:
CITY:	CITY:
STATE: ZIP:	STATE: ZIP:
PHONE:	PHONE:
ID #: GROUP #:	ID #: GROUP #:

INSURED INFORMATION (Responsible Party, if different from Patient)

NAME (LAST, FIRST):	HOME PHONE:	
SSN:	CELL PHONE:	
DATE OF BIRTH: / /	WORK PHONE:	
STREET ADDRESS:	CITY: STATE:	ZIP:
DRIVER LICENSE #:	RELATION TO PATIENT:	

CREDIT CARD INFO. on File: ☐ Visa, ☐ MC, ☐ AmEx, ☐ Discover.

Card number: _____ **Exp. Date**: _____; **CVV Code**: _____

Name on card: _____

ASSIGNMENT: I hereby assign and request payment of medical benefits be paid directly to RISING SUN PHYSICAL THERAPY & WELLNESS I also understand that I am financially responsible for any and all charges not covered by my insurance.

SIGNED: _____ DATE: / / _____

RELEASE OF INFORMATION: I hereby authorize the release of any medical information necessary to process my claims.

SIGNED: _____ DATE: / / _____

Rising Sun
PHYSICAL THERAPY & WELLNESS

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully and initial all the boxes indicating your agreement.

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in an ***$85 fee charged*** to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$85 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$85 fee will be*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing difficult financial times, there are many payment plans available.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. You may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a successful relationship with you that lasts a lifetime!

Rising Sun
PHYSICAL THERAPY & WELLNESS

Past Medical History Form

Patient Name: _____ Date: _____ / _____ / _____

Are you presently working? ❑ Yes ❑ No Current Job/Description: _____

Date of injury/onset: _____ / _____ / _____ Injured Body Part: _____

Have you ever had these symptoms before? ❑ Yes ❑ No If yes, when: ____

Check which applies to your current condition:

❑ Work-related Injury ❑ Recurrence of previous injury
❑ Motor vehicle accident ❑ Injury related to lifting ❑ Injury related to falling
❑ Cause unknown ❑ Athletic/Recreational injury ❑ Other: _____

Have you had a related surgery? ❑ Yes ❑ No
If female, are you pregnant? ❑ Yes ❑ No

Do you have, or have had any of the following:

	Yes	No		Yes	No
Diabetes	❑	❑	Hypoglycemia	❑	❑
Chest Pain/Angina	❑	❑	Osteoarthritis	❑	❑
High Blood Pressure	❑	❑	Osteoporosis	❑	❑
Heart Disease	❑	❑	Hernia	❑	❑
Heart Attack	❑	❑	Seizures	❑	❑
Heart Palpitations	❑	❑	Metal Implants	❑	❑
Pacemaker	❑	❑	Dizziness/Fainting	❑	❑
Headaches	❑	❑	Fracture	❑	❑
Kidney Problems	❑	❑	Surgeries	❑	❑
Cancer	❑	❑	Skin Abnormalities	❑	❑
Stroke	❑	❑	Nausea/Vomiting	❑	❑
Bowel/Bladder Abnormalities	❑	❑	Ringing in your ears	❑	❑
Urine Leakage	❑	❑	Rheumatic Arthritis	❑	❑
Asthma/Breathing Difficulties	❑	❑	Smoking	❑	❑
Liver/Gallbladder Problems	❑	❑	Other	❑	❑

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history

_____

_____

_____

_____

Do you have any allergies? ❑ Yes ❑ No
If yes, please list your allergies: _____

MEDICAL HISTORY AND PHYSICAL CONDITION QUESTIONAIRE

1. Check all that apply of what is either difficult to do, or that you are unable to do, due to the onset of your condition:

□ Sit	□ Lift	□ Overhead lift/ Reach
□ Stand up	□ Prolonged standing	□ Walk/ Run
□ Bend	□ Grip with hand	□ Sleep
□ Dress	□ Drive	□ Walk up or down stairs
□ Groom	□ Work at home	□ Work away from home

□ Other (please explain): _____

2. Check all goals you hope to reach from the physical therapy treatment program:

□ Decreased pain	□ Improved movement	□ Improved strength
□ Improved posture	□ Improved balance	□ Increased work ability
□ Improved home ability	□ Improved walking	□ Improved sleep

□ Other (please explain): _____

3. Are you currently under the care of a physician and / or health care provider? _____ Yes; _____ No.

   If yes, please provide full name: _____ and phone number: _____

4. Date of next physician's visit: _____ / _____ /_____

5. Please list any medications you are currently taking: _____

   _____

I certify that this information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance plan.

1. Benefit Info

What is your deductible amount? $_____ and Coinsurance %_____ (for the services you are seeking)

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

If you have a coinsurance or unmet deductible give your credit card info here. Nothing will be charged unless a balance due.

Credit Card Type _____ Exp. Date_____ Card #:_____

2. Policy Info

Patient Name:_____ ID #_____ DOB_____

Insurance Policy #:_____ Group #_____

Insured Name (if other than patient):_____Insured Date of Birth_____

Your relationship to the Insured: Parent Spouse Other:_____

Claim #_____

I hereby instruct and direct _____insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

Rising Sun Physical Therapy & Wellness

1601 Dove Street Suite 100

Newport Beach, CA 92660

Natsuko Watanabe

1601 Dove Street Suite 100

Newport Beach, CA 92660

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Initial each line and sign at the bottom)

_____ A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

_____ I authorize the use of this signature on all insurance submissions.

_____ I authorize the "Healthcare Provider" named above to deposit checks made in my name.

_____ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Policyholder_____Witness _____Signature of Claimant, if other than Policyholder_____

Date: _____

Statement of Privacy Notice

Effective June 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (949) 274-9551. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (949) 274-9551. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHCS, Privacy Officer
PO Box 997413 MS 4721
Sacramento, CA 95899-7413
Phone: 866.866.0602 Opt 1
Fax: 916.440.4680
Email: privacyofficer@dhcs.ca.gov

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Rising Sun Physical Therapy. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date