CORNERSTONE PHYSICAL THERAPY
7145 NORTH CHESTNUT AVE, SUITE 105
FRESNO, CA 93720

PHONE: 559-299-2244
FAX: 559-299-2487
EMAIL: CPTFRESNO@GMAIL.COM

New Patient Information

General

Date: _____

Last Name: _____

First Name: _____

Address: _____

_____

City: _____ Zip Code: _____

Reason for Referral: _____

_____

Date of Birth: _____

SSN: _____

Phone Number:

Primary: _____

Secondary: _____

Email: _____

Would you like appointment reminders:

Text: Yes [ ] No [ ] Email: Yes [ ] No [ ]

Referral Source:

MD [ ] Self [ ] Other: _____

Name of Physician: _____

If Work Comp:

Claim Number: _____

Claim Adjuster: _____

Occupation: _____

Emergency Contact Information:

Relationship: _____

Name: _____

Phone Number: _____

If Patient is a Minor, Parent/Legal Guardian Information:

Name: _____

Phone Number: _____

Address: _____

Adult Signature: _____

Are you the Primary Subscriber on Your Insurance Card: Yes [ ] No [ ]

If No, Please Provide Subscriber's Information for Billing Purposes:

Name: _____ Date of Birth: _____

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Medical History:	
Cardiovascular Disease: Yes [ ] No [ ] Describe: _____ _____	Cerebrovascular Accident / Stroke: Yes [ ] No [ ] Describe: _____ _____
Cancer: Yes [ ] No [ ] Describe: _____ _____	Gastrointestinal: Yes [ ] No [ ] Describe: _____ _____
Osteoarthritis: Yes [ ] No [ ] Surgical History: Yes [ ] No [ ] Describe: _____ _____	Diabetes (Type 1 / Type 2): Yes [ ] No [ ] Kidney / Urinary: Yes [ ] No [ ] Describe: _____ _____
Immunosuppression: Yes [ ] No [ ] Headaches: Yes [ ] No [ ] Height: _____ Weight: _____	Allergies: Yes [ ] No [ ] Describe: _____ _____

Medications			
Name	Dosage	Frequency	Route of Administration

CORNERSTONE PHYSICAL THERAPY

Medical Benefit Assignment and Consent to Treat:

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed for insurance carrier payments.

"No Show" Policy:

We dedicate our time to provide quality treatment and care in a timely manner to all our patients. **We have implemented a "no show" policy of $50.00 per incident**, which enables us to better utilize available appointments for our patients in need of care. Please be courteous and call our office promptly if you are unable to attend an appointment. Your early cancellation will give another person the opportunity to have access to timely physical therapy care.

Assignment of Benefits:

I hereby assign all medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Cornerstone Physical Therapy for medical services rendered regardless of my insurance benefits, if any. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE.

Consent to Treat/Release of Medical Information:

I, patient or authorized signatory, authorize any physician, surgeon, dentist, hospital, imaging center, rehabilitation facility, or insurance company to furnish Cornerstone Physical Therapy any and/or all medical records in their possession regarding my diagnosis and treatment of injuries/illness sustained on _____, 19____, 20____. This information will be used for pertinent medical purposes.

THIS AUTHORIZATION SHALL REMAIN VALID UNLESS REVOKED IN WRITING WITH NOTICE TO CORNERSTONE PHYSICAL THERAPY FOR ONE YEAR FROM THE DATE SIGNED.

Upon presentation of this authorization, or a photocopy of it, you are directed to release said medical records to Cornerstone Physical Therapy.

_____ _____ _____

Signature of Responsible Party **Printed Name** **Date**

CORNERSTONE PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We understand that information about you and your health is personal, and we are committed to protect your privacy. This Notice describes how we may use and disclose your protected health information, or PHI; to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control this information. Your PHI includes demographic information that may identify you and that relates to your health care services. These policies extend to any healthcare professional authorized to enter information into your chart, all departments of the Practice, all employees, staff and other personnel. We are required by law to abide by the terms of this Notice. We may change the terms of the Notice at any time, with the new Notice becoming effective for all PHI that we maintain at that time. Upon your request, we will provide you with revised Notice by calling the office and requesting a mailing copy, or asking for one at your next visit.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your PHI for any purpose other than treatment, payment or healthcare operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your PHI as necessary for your treatment Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medication, tests, medical history, etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your PHI as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your PHI as necessary, and as permitted by law, for our health care operation, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your PHI for purposes of improving the clinical treatment and patient care.

Individuals Involved in Your Care: With your written agreement we may from time to time disclose your PHI to designed family, friends, and others who are involved in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest; we may share limited PHI with involved individuals without your approval. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed though contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collections, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on your voicemail or sent to a particular address, we will accommodate reasonable requests.

Research: In limited circumstances, we may use and disclose your PHI for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use disclosure of patient information.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your PHI without your consent or authorization for the following:

• any purpose required by law.

• public health activities, such as required reporting of diseases, injury, birth and death, or required public health investigations.
• if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
• to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
• to your employer when we have provided health care to you at the request of your employer.
• to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
• court or administrative ordered subpoena or discovery requests.
• to law enforcement officials as requested by law to report wounds and injuries and crimes.
• to coroners and/or funeral directors consistent with law.
• if necessary to arrange an organ or tissue donation from you or a transplant for you.
• if you are a member of the military; we may also release your PHI for national security or intelligence activities; and
• to workers' compensation agencies for workers' compensation benefit determination.

YOUR RIGHTS

Right to Inspect and Copy your PHI: that may be used to make decisions about your care. This includes medical and billing records, but may not include some mental health information. To inspect and copy this information, you must submit your request in writing to our Privacy Officer. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request in limited circumstances. If you are denied access, you may request that the denial be reviewed—a separate licensed health care professional chosen by our practice will review your request. We will comply with the outcome of the review.

Right to Amend: You may ask us to amend any medical information we have about you if you feel the information is incorrect/incomplete. You can request an amendment in writing, along with your intended amendment and a reason to support your request. The request must be dated by you, and notarized. Send the request to our Privacy Officer. We may deny your request if you ask us to amend information that (I) Was not created by us, unless the person that created the information is no longer available; (2) is not part of the medical information kept by or for the practice; (3) is not part of the information you would be permitted to inspect and copy; or (4) is inaccurate or incomplete. If your request is denied, you may submit a written addendum (not to exceed 250 words) with respect to anything in your record you believe is incomplete/incorrect. IF you indicate in writing that you want the addendum to be part of your record it will be attached to your records, and included whenever we make a disclosure of the item or statement.

Right to an Accounting of Disclosures: This is a list of the disclosures we made of medical information about you to others. Your request must be in writing, must state time period of no longer than six (6) years back, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. The first list you request within a 12-month period will be free but we may charge you for the cost of additional lists. We will notify you of the costs prior to them being incurred. Please send your written request to our Privacy Officer.

Right to Request Restrictions: You may restrict or limit the information we use/disclose about you for treatment, payment or health care operations. You may request a limit on the PHI we disclose about you to someone involved in your care or payment for your care (family member of friend). We are not required to agree to your request and may not be able to comply with your request. If we agree, we will comply with your request unless we are otherwise required to disclose the information by law. To request restrictions, indicate in writing (1) what information you want to limit; (2) whether you want to limit use, or both; (3) to whom you want the limits to apply (e.g. parents, spouse, etc.). Send this written request to our Privacy Officer.

Right to Request Confidential Communications: You may request that we communicate with you about medical matters in a certain way or at a certain location. You may, for example, ask that we only contact you at work, by mail, that we not leave voice mail, etc. Your request must be in writing. We will not question the reason for you request, and we will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You are entitled to a paper copy of this Notice.

Filing Complaints: If you believe your privacy has been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services, at (877) 696-6775. To file a complaint with our Practice, contact the Privacy Officer at (559) 299-2244 or in writing. **You will not be penalized for filing a complaint.**

_____ _____

Patient Signature (or legal guardian) **Date**