Sierra Orthopaedic and Athletic Rehabilitation

_____

(Full Legal Name) **Last** **First** **MI** **Date of Birth** **Occupation**

Mailing Address: _____
Street/P.O. Box **City** **State** **Zip Code**

Residence (if different): _____
Street **City** **State** **Zip Code**

(_____)_____(_____)_____
Home Phone **Work/Cell Phone** **Marital Status** **Age** **Gender** **Social Security #**

Referring Physician: _____
Name of MD, DPM, DC, DO **Date of injury/or onset of symptoms**

Email address_____**(for appointment reminders only)**

1. Is this condition related to an injury on the job? YES____ NO____ (If yes, was a claim filed? YES_____ NO_____)

2. Were you treated elsewhere for this injury? Chiropractic included. YES____ NO____ (If yes, No. of treatments? _____)

3. Is this injury related to a motor vehicle accident? YES____ NO____

4. Is this injury involved in litigation? YES____ NO____ (If yes, provide attorney information below)

_____ _____
Primary Insurance Company Name **Secondary Insurance Company Name**

Name of Insured: _____
(If different from Patient) (Spouse or Parent) Social Security # Date of Birth

If party is a minor: _____
Name of **Insured** Parent Social Security # of **Insured** **Insured's** Date of Birth

Workers' Comp Info: _____
Employer Name Address Phone

Litigation information: _____
Attorney Name Address Phone

FOR OFFICE USE ONLY

Insurance_____ID/Claim#_____Grp#_____

Address_____

Phone ( ) _____ Fax ( ) _____ Claim/Rep/Adjuster_____

Eff Date_____ Ded Ind_____Ded Fam_____ Met_____ Cov%_____Chiro_____Rx Req'd:_____ # of visits_____ Co-Pay_____

_____

2° Insurance_____ID/ Claim#_____Grp#_____

Address_____

Phone ( ) _____ Fax ( ) _____ Claim/Rep/Adjuster _____

Eff Date _____ Ded Ind_____Ded Fam_____Met_____ Cov%_____Chiro_____Rx Req'd:_____# of visits_____Co-Pay_____

Date Consulted _____ Provider: RK KE BB Diagnosis_____

NP RP New Case New Diagnosis _____

Patient Name: _____ Date:_____

Have you EVER been diagnosed as having any of the following conditions? If yes, briefly describe:

_____

YES	NO	Cancer	YES	NO	Heart Problems
YES	NO	High Blood Pressure	YES	NO	Diabetes
YES	NO	Asthma	YES	NO	Lung Disease
YES	NO	Allergies	YES	NO	Joint Problems
YES	NO	Thyroid Problems	YES	NO	Kidney Disease
YES	NO	Liver Disease	YES	NO	Neurological Disease
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Depression	YES	NO	Chemical Dependency (alcohol, medication)

Do you smoke? YES NO If yes, how much, and for how long? _____
Do you drink alcoholic beverages? YES NO If yes, how much and how often? _____
Do you have frequent or unusual headaches? YES NO Describe: _____
Do you have any metal implants (joint replacements/plates/rods)? YES NO Where?_____
Do you have a pacemaker? YES NO
What is your current weight? _____ How tall are you?_____
FOR WOMEN: Are you currently pregnant or do you think you might be? YES NO

Please list your medications (including <u>all</u> prescribed, herbal or homeopathic and over-the counter):

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate dates:

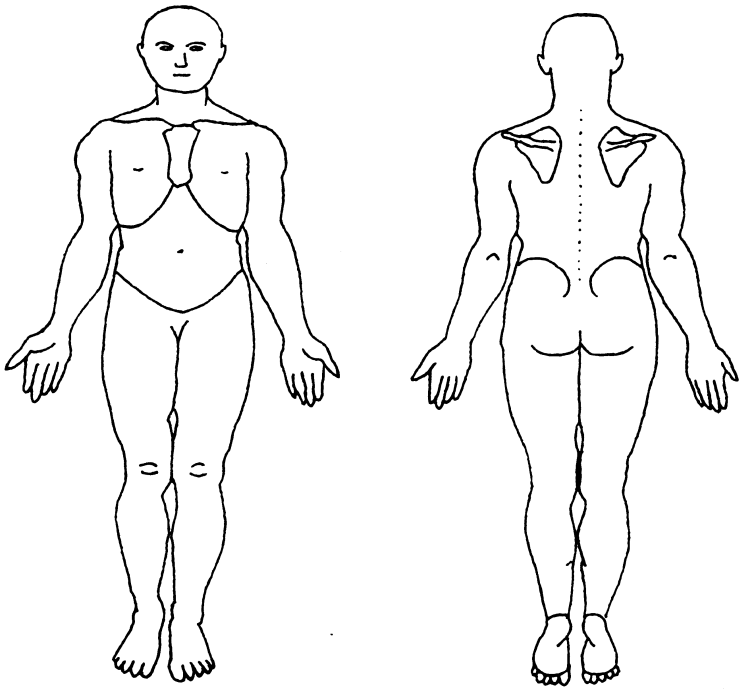
Who is your primary care physician? _____

Have you had chiropractic or massage therapy treatments this year? YES NO If yes, by whom and when:

_____

Symptoms Drawing

Please draw on the body chart where you feel problem(s) and briefly describe your symptoms (e.g.: sharp, ache, tingling, etc…) next to where you feel them.



Sierra Orthopaedic and Athletic Rehabilitation Company Policies

Financial Policy: Patients must recognize that they are responsible for the charges incurred for physical therapy (Worker's Compensation excluded, although **prior authorization is required**). We will submit billing to your insurance, free of charge for physical therapy services. You are responsible for knowing what your benefits are. In the event your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment.

Medicare Policy: The 2015 therapy cap has been set at $1,940 per year, although some diagnoses are exempt. If your diagnosis is exempt, Medicare must approve all treatment that exceeds $3,700. Patient is responsible for all charges that exceed the $3,700 threshold if Medicare finds treatments to be medically unnecessary.

Lien of Personal Injury Policy: If you were involved in a motor vehicle accident we will submit billing to your insurance. A lien of personal injury must be signed. A good faith payment must be paid at each visit or payment arrangements can be made prior to treatment. Any applicable co-payments will be accepted as a good faith payment.

Attorney Lien Policy: If you sustained a personal injury and retained an attorney, our office must receive a signed lien by patient and attorney by the third visit or you will be charged for each visit thereafter until signed lien is received.

Durable Medical Equipment (DME) and Custom Orthotics Policy: We do not bill for DME (Worker's Compensation excluded, although **prior authorization is required**). Medicare patients must sign an **A**dvanced **B**eneficiary **N**otice (ABN) for orthotics, since they are not a covered benefit. A deposit must be paid prior to ordering the orthotics.

Attendance Policy: We ask that you read and agree to comply with our Attendance Policy. A 24-hour cancellation notice is required. A $20.00 fee will be charged to your account if you neglect to notify us within 24 hours. We have a strict "No-Show" policy. If you do not show for your scheduled appointment and have not called to cancel, you will be marked as a "No-Show", and a $20.00 fee will be charged to your account. All future scheduled appointments will be cancelled if there are more than two no shows in a row.

Authorization and Assignment of Benefits

I hereby authorize and direct you, my insurance company, to pay directly to Sierra Orthopaedic and Athletic Rehabilitation such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and without such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the office's services provided.

Patient signature: _____

Name Date

If party is a minor: _____

Name of Parent/Guardian Date

SIGNATURE CONSTITUTES ACCEPTANCE OF COMPANY POLICIES AND CONSENT TO TREATMENT.

Sierra Orthopaedic and Athletic Rehabilitation

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 INFORAMTION. PLEASE REVIEW IF CAREFULLY.

When you receive healthcare services from us, we will obtain access to your medical information. We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Documentation: You will be asked to sign an Authorization/Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our office. You may take back or revoke your consent or authorization at any time by submitting our Revocation Form in writing. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your Authorization/Acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your Authorization/Acknowledgement to provide services before you revoked it).

General Rule: If you do not sign our Authorization/Acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment, and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our Authorization/Acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an Authorization/Acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Authorization/Acknowledgement or revoke it.

Healthcare Treatment, Payment and Operations Rule: With your signed consent, we may use or disclose your PHI in order to: 1) Provide you with or coordinate healthcare treatment and services. 2) Bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party (e.g., we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan). 3) Run our office, assess the quality of care our patients receive and provide you with customer service.

Special Rules: In accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- In emergencies to prevent a serious threat to your health and safety or the health and safety of others
- When necessary for public health reasons
- For federal or state government health-care oversight activities
- For judicial and administrative proceedings and law enforcement purposes
- For Worker's Compensation purposes
- For intelligence, counterintelligence or other national security purposes
- To family members, friends and others, but only if you are present and verbally give permission, or you allow them to pick up your records but only in writing with your signature to do so

Minimum Necessary Rule: Our staff will not use or access your PHI unless it is necessary to do their jobs. Billing staff will not access your PHI except as needed to complete claim forms. All of our team members are trained in HIPAA Privacy Rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. Know that your PHI is protected several layers deep with regards to our business relations. Still in certain cases, we may use and disclose the entire contents of your medial record to: 1) You or your legal representative(s) and anyone else you list on a Consent or Authorization to receive a copy of your records. 2) Healthcare providers for treatment purposes, 3) The U.S. Department of Health and Human Services. 4) Others as required under federal or state law. 5) Our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA.

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review requests for PHI to determine the minimum necessary amount to PHI and disclose only that. If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule: We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it. We shred all paper containing PHI, require employees to speak with privacy precautions when discussing

PHI with you. We use computer passwords and change them periodically. We use firewall and router protection to the federal standard. We back-up our PHI data.

In the event that there is a breach in protecting your PHI, we will follow Federal Guidelines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the Department of Health and Human Services. We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule: Business Associates are defined as: an entity, (non-employee such as IT Tech, Billing, etc.) that in the course of their work will directly/indirectly use, transmit, view, transport, hear, interpret, or process PHI for this Facility. Business Associates that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law. Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us.

Super-confidential Information Rule: If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, psychotherapy and mental health records, we will not disclose it under the General or Healthcare Treatment, Payment and Operations rules without your first signing and properly completing our consent form.

Changes to Privacy Policies Rule: We reserve the right to change our privacy practices at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past. If we make changes we will post it in our office and on our website along with its effective date. Also upon request, you will be given a copy of our current Notice.

Authorization Rule: We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization/Acknowledgement form.

Marketing, Fundraising and Research Rules: Under the new HIPAA Omnibus Rule, your PHI can be used for marketing, fundraising, and research with written authorization by the patient.

Your Rights To Inspect and Copy: You have the right to look at or get copies of your PHI with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may ask us to give you the copies in a format other than photocopies and we will do so unless we determine that it is impractical. We may charge you a fee not to exceed state law to recover our costs.

Your Rights To Request Amendment / Correction: If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Your Rights To an Accounting of Disclosures: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your PHI in accordance with applicable laws and regulations. Your request must state the time period you want us to cover, which may be up to but not more than the last six years. If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Your Rights To Request Restrictions: You may ask us to limit how your PHI is used and disclosed by submitting a written "Request for Restrictions on Use, Disclosure" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request if we are required by law to use or disclose your PHI in a manner that you want restricted.

Your Rights To Request Alternative Communications: You may ask us to communicate with you in a different way or at a different place by submitting a written "Request for Alternative Communication" Form to us. We will not ask you why and we will accommodate all reasonable requests. You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

Your Rights To Complain or Get More Information: We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communication), we want to make it right. To do so, please file a formal, written complaint within 180 days with to: The U.S. Department of Health & Human Services Office of Civil Rights. We will provide you with the address upon request.

Or, submit a written Complaint form to us at the following address:
Diane Pyeatt/ Privacy Officer
Sierra Orthopaedic & Athletic Rehabilitation
4300 Golden Center Drive, Suite B
Placerville, CA 95667
Office Phone: 530.344.2045 Office Fax: 530.642.0794

Sierra Orthopaedic and Athletic Rehabilitation

PATIENT ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT NOTES BE SENT TO OTHER DOCTOR/ FACILITYS IN THE FUTURE**.

_____ _____

Please print your name Please sign your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

___First Name Only ____Other_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:(This includes stepparents, grandparents and any caregivers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM AN APPOINTMENT, TREATMENT & BILLING INFORMATION** VIA:

___Home Phone Confirmation ___Cell Phone Confirmation___Work Phone Confirmation
___**Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

___Home Phone Confirmation ___Cell Phone Confirmation___ Work Phone Confirmation___
___**Any of the above**