

**MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ Pt#: \_\_\_\_\_

Do you now have (or have you had) any of the following? Please circle Yes or No.

High Blood Pressure	Yes	No	Nervous Disorders	Yes	No
Diabetes	Yes	No	Allergies to:		
Heart Attack	Yes	No	Heat	Yes	No
Heart Disease	Yes	No	Ice	Yes	No
Pacemaker	Yes	No	Latex	Yes	No
Headaches	Yes	No	Other	Yes	No
Kidney Problems	Yes	No	Hernia	Yes	No
Seizures	Yes	No	Cancer	Yes	No
Metal Implants	Yes	No	HIV	Yes	No
Surgery	Yes	No	Currently Pregnant	Yes	No
Osteoporosis	Yes	No	Currently Nursing	Yes	No
Stroke	Yes	No			

If you answered "Yes" to any of the questions above, please explain, including dates of illness, condition and/or surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above medical information is correct to the best of my knowledge.

\_\_\_\_\_  
(Signature of Patient and/or Parent if Patient is a Minor) Date: \_\_\_\_\_

## FINANCIAL ARRANGEMENTS, MEDICAL INSURANCE AND HIPPA

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will bill your private insurance company for our services. Bills are processed two times each month; after the 15th of the month and at the end of the month. We require that you pay your co-pay during each visit and will inform you of your yearly deductible that has not yet been met and you will be held responsible for this amount regardless of what other arrangements have been made regarding your treatment fees. Upon receipt of your statement, we require that you pay the percent of our charges that are not covered by your insurance policy. Although it is not always possible to give exact costs for therapy services, as treatment and supplies may vary, we will inform you of additional costs when possible. We accept cash, checks, MasterCard and Visa.

Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice.

An itemized statement will be sent to you monthly and at the end of your treatment and after all monies have been received from your insurance company. Any overpayments will be promptly refunded.

Please note the following:

- ▶ Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- ▶ Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 80%) of the "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies but not all. Therefore, any balance not paid by the insurance company will be your responsibility.
- ▶ Not all services, supplies are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain service/supplies they will not cover. The cost for these services/supplies will be your responsibility.

We must emphasize that as physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us immediately for assistance in the management of your account.

Finally, by signing this page, you agree that you have received a copy of Ergo-Rehab's patient privacy rights as they pertain to the Health Insurance Privacy & Portability Act (HIPPA).

If you have any questions concerning our billing policies, cancellation/no-show policy, or HIPPA rules and regulations and our privacy policy, PLEASE do not hesitate to ask. We are here to help!

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to Ergo-Rehab, Inc. for the medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. If my current policy prohibits direct payments to Ergo-Rehab, Inc., I hereby also instruct and direct you to make out the check to me and mail it to the above address. This is a direct assignment of my benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee. I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Ergo Rehab, Inc. and its employees to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

(Signature of Claimant, if other than policyholder)

## **Ergo-Rehab**

### **NOTICE OF PATIENT INFORMATION PRACTICES**

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

#### **ERGO-REHAB'S LEGAL DUTY**

ERGO-REHAB is required by law to protect the privacy of your personal health information, provide this notice about our practices and follow the information practices that are described herein.

#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

ERGO-REHAB uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ERGO-REHAB may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. ERGO-REHAB may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, ERGO-REHAB's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. ERGO-REHAB may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

#### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ERGO-REHAB will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

#### **CONCERNS AND COMPLAINTS**

If you are concerned that ERGO-REHAB may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ERGO-REHAB's health information practices or if you have a complaint, please contact the following person:

*ERGO-REHAB  
Office Administrator  
39201 State Street  
2675 Stevenson Blvd.  
Fremont, CA 94538  
tel: 510-791-5521  
info@ergo-rehab.com*

## SUCCESS WITH PHYSICAL THERAPY

**APPOINTMENTS:** We assume you will attend all your Physical Therapy appointments, arriving on a timely basis. Your Physical Therapy appointment will typically take 1 hour unless we notify you of longer times. Every attempt is made to run on time. Therefore, it is important for you to arrive for your appointments on time. The success of Physical Therapy depends upon consistent attendance of your visits and at the prescribed frequency and duration.

**PHYSICIAN APPOINTMENTS:** It is very important that you attend all of your physician appointments as our Therapists and your referring Physician work closely together. Please be sure to inform your Therapist when you have a doctor appointment scheduled so they have time to send a progress note to notify your doctor how you are doing.

**ABSENCE** In order to assist in your rehabilitation, we feel you must attend scheduled appointments. If two appointments are missed without a reasonable explanation, you are notified of the termination of Therapy. With workers compensation patients, employers and insurance adjusters are also notified of missed appointments.

**CHILDCARE:** No childcare is provided at this facility. Children may stay in the waiting area with supervision.

**CELLULAR PHONES/2 WAY RADIOS:** Please turn off these devices when in the Therapy department. Cellular phones and 2 way radios interfere with sensitive therapy equipment. Furthermore, as a courtesy to other patients and the Therapists, any calls should be conducted outside of the building.

I acknowledge that I have read and understand the above policy:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Satisfaction Survey

Patient Identification Number	Tracking Number	Survey Date	MM	DD	YYYY

For your current rehabilitation treatment, how satisfied were you with:	Very Satisfied	Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Somewhat Dissatisfied	Very Dissatisfied
1. The information your therapist gave you about your condition?					
2. The therapist's inclusion of your input in setting treatment goals?					
3. The availability of convenient therapy appointments?					
4. Access to this facility location?					
5. The level of courtesy and respect shown to you by the staff at this facility?					
6. The therapy treatments for your condition?					
7. Overall results of your therapy treatment?					
8. Based on your experience at this facility, you would say to a friend, "I was ... "					

