Rise Pacific Physical Therapy and SPORTS MEDICINE

It's Time to RISE.

GUIDELINES AND POLICIES FOR PHYSICAL THERAPY PATIENTS

- When you arrive for therapy, please be seated. Your therapist will call you back.
- Please be prompt! Our therapists strive to make your wait time less than 5 minutes from your appointment time. Please show them and other patients the same courtesy. If you are more than 15 minutes late, we will need to reschedule your appointment.
- If you show 30 minutes before your scheduled appointment time and we are busy you may have to wait until your scheduled time as other patients have appointments also.
- Please be prepared to PAY YOUR CO-PAY OR CO-INSURANCE AT EACH VISIT. If you have questions about your insurance please review your insurance policy, or we can help you with clarification.
- Patients under the age of 18 must be accompanied by a parent or legal guardian.
- For our patients with young children: Due to insurance liabilities we cannot allow children in the gym. Please make arrangements for them while you are attending your appointments.
- **Office hours**: By appointment only, Monday thru Friday. If you call during non-office hours, you may leave a voice message.

CANCELLATION / NO-SHOW POLICY

- If you need to cancel or reschedule your appointment for any reason, we require 24 hours notice (except extenuating circumstance), as we are holding a spot for you in our schedule that other patients could use. Failure to contact our office to cancel your appointment 24 hours prior to your appointment more than once may result in our inability to continue holding a spot for you in our schedule.
- No-Shows (not showing up for your appointment with no phone call to the office or therapist) are not acceptable as your therapist has blocked one-on-one time for your care. After one No Show, we may be unable to continue holding a spot for you in our schedule.
- Preferred method to be contacted by our staff regarding upcoming appointments (please check one):

☐ Phone Call	☐ Text Message
Phone Number:	

We look forward to working with you,

Gina Meyer, DPT
Physical Therapist/Clinic Director

I have read or had this information explained to me to my satisfaction, and I agree to comply with all clinic guidelines and the Cancellation/No-Show Policy.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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PATIENT REGISTRATION

A. Patient Information					
First Name:		Middle Initial:	Last Name:		
Address:		City:	State:		Zip:
Email:		DOB:	SSN:		
Home Phone:	Cell:		Work:		
Physician Name:	Date of Last Appt:		Phone:		
Are you a student? ☐ YES ☐ NO: If YES, what school do you attend? Grade Level:					

B. Emergency Contact Information		
First Name:	Middle Initial:	Last Name:
Relationship: ☐Spouse ☐Parent ☐Friend ☐Other:		Phone Number:

C. Parent/Guardian Information (Only fill out if patient is a minor)				
First Name:		Middle Initial:	Last Name:	
Address:		City:	State:	Zip
Relation to Patient:		DOB:	SSN:	
Home Phone:	Cell Phone:		Work Phone:	

D. Employer Information			
Name of Employer:		Occupation:	
Address:	City:	State:	Zip:

E. Insurance Information: Will we be billing insurance? ☐ YES(Please provide insurance card) ☐NO			
Name of Insurance Carrier:	Policy#:	Group#:	
Subscriber (Insured) Information: **Check Here** ☐ if Name, Address, Employer, DOB and SSN, are same as patient.			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Employer:	DOB:	SSN:	

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MEDICAL HISTORY

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you!

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

Cancer	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO
Heart Disease	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO
Metal Implants	☐ YES ☐ NO
Respiratory Problems	☐ YES ☐ NO
Psychological Problems	☐ YES ☐ NO
Are you pregnant?	☐ YES ☐ NO
Do you have allergies	☐ YES ☐ NO

If yes, what _____

Please list any additional medical conditions of which we should be aware:

Current Medications: _____

Surgeries (What/Where/When): _____

Recent Illness (What/When): _____

Work Related Injury	
Were you injured at work? ☐ YES ☐ NO	Date of Injury (MM/DD/YY):
Name of Compensation Carrier:	Claim #
Address:	

Auto Related Injury	
Were you injured in a traffic accident? ☐ YES ☐ NO	Date of Accident (MM/DD/YY):
Name of Auto Insurance Carrier:	Ins. Co Phone Number:
Policy #:	Claim #:
Address:	

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

DATE: _____
PATIENT: _____
PATIENT DOB: _____
PATIENT PHONE NUMBER: _____
PERSON/DOCTOR(S) WITH WHOM WE MAY DISCUSS YOUR SCHEDULE OR CARE: _____
_____

WORKER'S COMP PATIENTS

_____ here by authorizes the release of protected health information such as number of cancelations and no show appointments resulting in non-compliance of therapy to my case manager _____ (name of person or referring provider) and any or all notes or bills pertaining to the payment of my treatment or continued care at another facility.

PROVIDER NAME/FACILITY: **Rise Pacific Physical Therapy and Sports Medicine**
ADDRESS: **195 E. Hillcrest Dr. Ste 114**
CITY/STATE/ZIP: **Thousand Oaks, CA 91360**
PHONE NUMBER: **(818) 318-2430**
FAX NUMBER: **(817) 287-1195**

By signing this authorization, I understand that I or the above signed, have the right to receive a copy of my records upon written request; anyone seeking information regarding my treatment at this facility has permission. You as the patient will be notified of any such person wanting information pertaining to your therapy with this office. This authorization is valid for one year from date of signature, unless otherwise revoked in writing. A copy of this authorization gives the same rights and permissions as the original.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

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CONSENT FOR CARE AND PRIVACY PRACTICES

CONSENT FOR CARE AND TREATMENT

I understand and agree that I am responsible to make payments on my account and if I fail to make any of the payments for which I am responsible in a timely manner, that I am responsible for interest as well as for all collection costs including but not limited to court costs, collection agency fees, and attorney fees. I, the undersigned, do hereby agree and give my consent for Rise Pacific Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

CONSENT TO TREATMENT OF A CHILD *(only fill out if patient is a minor)*

I hereby authorize Rise Pacific Physical Therapy and Sports Medicine Therapists and Assistants to administer treatment to my son/daughter (circle/one), _____ as they deem necessary and appropriate.

Signed: _____ Date: _____

Relationship to patient: _____

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the "HIPPA Notice of Privacy Practices" for Rise Pacific Physical Therapy and Sports Medicine. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Rise Pacific Physical Therapy and Sports Medicine to release any of my protected healthcare information.

My signature below acknowledges that I have read this document and understand the responsibilities I am expected to uphold and understand my rights as described herein.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT/GUARDIAN PRINTED NAME: _____ DATE: _____

PATIENT'S NAME (If not same as above): _____