812 Emerald Bay Rd.
South Lake Tahoe, CA 96150

Phone: 530-542-2662
Fax: 530-542-2661

PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Address: _____

_____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Occupation: _____ Physical job demands: _____

How did you hear about us, or who referred you to us?

_____

EMERGENCY CONTACT

Name:_____ Relationship to Patient: _____

Phone Number: _____

INSURANCE

Please provide a copy of your driver's license and insurance card to the office manager.

- **Workers Compensation** – Fill out the information below:

  SSN: _____ -_____-_____

  Employer Company Name:_____

  Employer's Address: _____

  _____

  Employer's Phone Number: _____

- **VA / Medicare** – Fill out the information below:

  SSN: _____ -_____-_____

MEDICAL SCREEN

Have you undergone previous treatment for this condition / injury?

- If yes, please describe: _____

What are your treatment goals? _____

Date of injury:_____/_____/_____ Date of surgery:_____/_____/_____

Please circle the severity of pain you experience:

Worst Pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

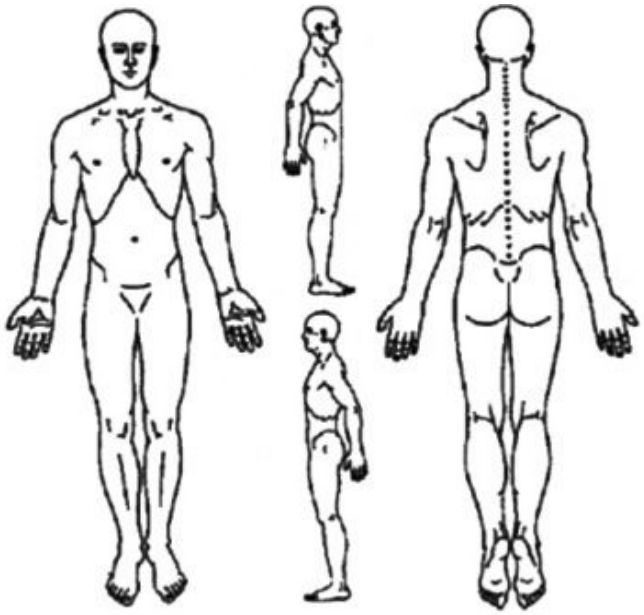
Average Pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please circle the type of pain or sensation you experience:

Aching	Stiff	Shooting	Numb	Cramping
Dull	Swelling	Sharp	Tingling	Burning

Other:

Please mark on the diagram the location of pain and symptoms you experience:



MEDICAL SCREEN

Please list all current medications: _____

_____

Please circle all conditions have had or currently experience:

Diabetes	High blood pressure	Stroke	Heart disease
Cancer	Kidney problems	Seizures	Heart attack
Allergies	Metal implants	Fibromyalgia	Pacemaker
Hernia	Osteoporosis	Osteoarthritis	Neck/Back pain
Headaches	Sensitivity to heat or ice	Asthma	Rheumatoid arthritis

Other:_____

SCHEDULING POLICY

Please schedule each appointment with us directly. We advise scheduling in advance to obtain optimum times. Please be advised that we require 24 business hours notice to cancel an appointment. We are not open weekends; therefore, a Monday cancellation must be provided by the preceding Friday. If you are unable or feel you should not attend an appointment, please call to discuss your options with us. **You, not your insurance provider, are responsible for any cancellation/no show charges and will be billed directly as follows:**

- **No Call / No Show: $50**
- **Cancelling without 24 business hours notice: $25**

FINANCIAL POLICY

We are committed to providing you with the best care possible. We will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to that contract in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles,

co-payments, covered charges, secondary insurance, “allowable” charges, etc., other than to supply factual information as necessary.

I authorize my insurance company to pay Emerald Bay Physical Therapy directly for my care. I understand that I am responsible for all charges not covered by my insurance. Deductibles and copayment amounts are required at the time of service unless other arrangements have been authorized by the office or billing manager. If payment is not received from the insurance company within 45 days, it becomes the patient’s responsibility, and there will be a 1.5% per month interest charge on all remaining balances. You are responsible for timely payments of your account. Should this account become delinquent, you will be responsible for all reasonable costs of collection.

WORKER’S COMPENSATION

We will bill your employer’s industrial insurance. If your injury is determined to NOT be work related, you will be responsible for the balance due within 30 days, or we reserve the right to bill any private insurance company you maintain.

LIENS

Upon verification by your attorney, we will accept your lien. The patient understands that we will be paid the full balance of our bill once the case settles.

PATIENT INFORMATION CONSENT POLICY

I authorize Emerald Bay Physical Therapy to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice in advance. I also understand that Emerald Bay Physical Therapy will consider requests for restriction on a case-by-case basis, but the facility does not have to agree to requests for restrictions.

Please name any non-healthcare related persons with whom you authorize us to share your personal health information (e.g. Listing your significant other will allow them to pick up any paperwork or records on your behalf.)

Name of authorized party: _____

TREATMENT CONSENT POLICY

I authorize Emerald Bay Physical Therapy to provide any and all treatment which they, in their professional judgment, feel will help my condition improve. I understand that they cannot

guarantee success and that some forms of treatment are painful. I understand that most therapy requires my participation and that my adherence to my home exercise program is necessary for continued success.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, read, or have been given the opportunity to review a copy of the Notice of Privacy Practices. I am aware that Emerald Bay Physical Therapy will provide a copy of the Notice of Privacy Practices at any time upon request. The Notice of Privacy Practices provides detailed information about how Emerald Bay Physical Therapy may use and disclose my confidential information.

I acknowledge that I have read and understand ALL of the above policies and that I have completed the requested information to the best of my ability.

Patient's Name _____

Patient's Signature _____ Date_____/_____/_____

To be completed by the patient's representative if necessary, e.g., if the patient is a minor or is physically or legally incapacitated.

Patient's Name: _____

Representative's Name: _____

Representative's Signature: _____

Relationship/Authority to Patient: _____

Date: _____/_____/_____