575 EAST HARDY STREET SUITE #105
INGLEWOOD, CA 90301
OFFICE: (310) 412-0100 FAX: (310) 988-2654

WELCOME SHEET

*DATE: _____

*ARE YOU CURRENTLY ENROLLED IN HOME HEALTH? Y ( ) N ( )

IF YES, WHAT IS THE NAME OF THE HOME HEALTH AGENCY? _____

*WHO REFERRED YOU TO OUR CLINIC? _____

*Patient Name: _____ *Sex: MALE ( ) FEMALE ( )

*Date of Birth: _____ *Primary Insurance: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*Phone: _____ Email: _____

Marital Status: M ( ) S ( ) Widowed ( ) Divorced ( )

*Emergency Contact: _____ *Phone: _____

Primary Language: _____

Do you need an Interpreter? YES ( ) NO ( ) If Yes, Which Language? _____

Social Security Number: _____

REFERRING PROVIDER INFORMATION

*Provider's Full Name: _____

*Address: _____

*City: _____ *State: _____ Zip Code: _____

*Office Phone: _____ Fax Number: _____

IS YOUR INJURY THE RESULT OF AN AUTO ACCIDENT? Y ( ) N ( )

IF SO, DO YOU HAVE AN ATTORNEY? Y ( ) N ( )

ATTORNEY'S NAME/ADDRESS: _____

_____

*required field

MEDICARE ONLY ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf of RJ PHYSICAL THERAPY GROUP, INC for any services furnished to me by the same. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, as well as any information needed to determine these benefits payable to related services.

I understand my signature indicates that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim form or electronically submitted claims, any signature authorizes releasing of the information to the insurer or agency shown. In Medicare assignment cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP ASSIGNMENT OF BENEFITS (SECONDARY INSURANCE)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to RJ PHYSICAL THERAPY GROUP, INC for any services furnished to me by the same. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original.

Signature of Patient or Authorized Agent: Date:

_____

RJ PHYSICAL THERAPY GROUP

INFORMED CONSENT AND AGREEMENT TO RECEIVE

PHYSICAL THERAPY SERVICES

(PLEASE READ INFORMED CONSENT FORM CAREFULLY)

1. I hereby consent to the provision of medically necessary physical therapy services as prescribed by physician and/or physical therapists in accordance with a Plan of Care.

2. I understand that the provision of physical therapy services depends on an ongoing determination of medical necessity by my physician and/or physical therapists. In addition, I understand that Ronnie Johnson, Jr., DPT, may decide to provide the care I require in my home environment, if necessary.

3. I understand that in the event my insurance company denies payment to RJ PHYSICAL THERAPY GROUP, INC. or RONNIE JOHNSON, JR., DPT, in any form, that I am and will be responsible for payment of services rendered to me at RJ PHYSICAL THERAPY GROUP, INC.

4. I have read and understood the information provided in this form. The nature of physical therapy services that I will receive are the risks and benefits associated with those services, and my caregivers' responsibilities have been adequately explained to me. I authorize and consent to the provisions of physical therapy services under the care of RONNIE JOHNSON, JR., DPT.

*Patient Name: _____

*Signature of Patient: _____

*Date: _____

RJ PHYSICAL THERAPY GROUP

NOTICE OF PRIVACY PRACTICES

At RJ PHYSICAL THERAPY GROUP, we have always kept your health information secure and confidential. As a result of the HIPPA (Health Insurance Portability and Accountability Act of 1996), we are required to maintain your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

HOW YOUR HEALTH INFORMATION MAY BE USED

The law permits us to use or disclose your health information to those involved in providing you with the best physical therapy care as possible. We may share your health information with physicians, referring physical therapists/ physical therapy assistants, occupational therapists, speech language pathologists, or other health care personnel providing you treatment.

We may use or disclose your health information to collect payment for treatment you may receive from our practice. We will ensure that the companies we work with share a similar commitment to your privacy and security.

Your health information may be used for our normal health care operations. We *may* use or disclose your health information to train staff, interns**,** associates, and business and clinical associates. It is also possible for your health information to be disclosed to insurance companies or government agencies as part of their quality assurance and compliance reviews. Furthermore, your health information may be reviewed during routine credentialing, certification, or licensing processes**.**

With your permission, we will share your health information with people who will be assisting you with treatments. In the event of an emergency, we will use our best judgement when sharing this information with those who are providing their assistance.

PATIENT RIGHTS

You have the right to request in writing that we do not use or disclose your health information as described above. We will make every effort possible to honor reasonable requests.

You have the right to request credential communications that might include sealed communications via mail or communications to a particular address or telephone number.

You have the right to review and receive a copy of your health information after providing a written request regarding the information you want to review. A copy of your records can be obtained for a reasonable fee to cover duplicate costs.

RJ PHYSICAL THERAPY GROUP

You have the right to request an amendment or change to your health information if you believe that your records are incorrect or incomplete. This request must be in writing and may or may not result in any changes. We will not remove nor alter any existing documents, but we will add your statement or any new information to your file.

You have the right to obtain a copy of this notice.

You have the right to file a complaint with the Secretary of Health and Human Services if you feel your privacy is compromised. However, we encourage you to express any concerns or complaints directly with us so that we can work together to create a more comfortable and confidential environment.

This notice goes into effect April 14, 2003. After this date, you have the right to request an accounting of the disclosures made in the previous six (6) years. These disclosures will not include those made for treatment, payment, or healthcare operations for which we have obtained authorization.

OUR DUTY TO PROTECT YOUR PRIVACY

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your protected health information. These rules require us to provide you with this document or Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice.

PRIVACY CONTACT

If you would like more information about our privacy practices or to file a complaint, you may contact:

Name: Ronnie Johnson, JR., DPT
Phone: (310)-412-0100

Title: Privacy Officer
Effective Date: April 14, 2003

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____