**INSURANCE TYPE:** PRIVATE MEDICARE WORKERS COMP CASH **DATE:**_______________

PATIENT NAME: ______________________________________ PH#: ___________________________
CELL#: ___________________________ WORK#: ______________________________________
(NO P.O. BOX)
ADDRESS: __________________________________CITY: __________________ZIP: ______________
Date of Birth: ________________ Age: __________ Sex: M F Soc. Security#: ______________________

EMPLOYER: ________________________________________PH# :_____________________________

E-mail Address: ________________________________________

EMERGENCY CONTACT: ______________________________PH#: ____________________________

**REFERRAL INFORMATION:** Next MD appointment: ___________________________________
*Who referred you to our office?* SELF DOCTOR FRIEND / RELATIVE INSURANCE COMPANY

**DIAGNOSIS:** ___________________________ **BODY PART:** _____________________________________

**REFERRING PHYSICIAN INFORMATION**

NAME: _______________________________________ NPI#________________________________
***Have you had home health care in the last 60 days?*** YES NO ***(IF YES)*** Company Name: _____________________

Ph# ________________ Release Date: _____________ DX CODE: ______________________________

**INSURANCE INFORMATION**
*PRIMARY INSURANCE* ______________________________________ PH#_______________________
Address: _______________________________City:____________________Zip:__________________
Insured's Name: _______________________________ Relationship to Pt: __________________________
I.D.#: ________________________________Group#_______________________________________
Case Manager: __________________________ Ph#___________________ Claim#__________________
D.O.I: ___________________ Fax # __________________
Electronic Payor ID #_________________________________
*SECONDARY INSURANCE*___________________________________ PH#___________________________
Address: _______________________________City: ____________________ Zip: __________________
Insured's Name: _________________________ Relationship to Patient: ________________________
ID#__________________________________ Group#: _______________________________________

**PRIMARY Benefits**

DED: ______________ Remaining: _______________ OOP MAX: _____________ Remaining: ____________
PT PAID IN _________% OUT _________% CO-PAY_________ **POLICY LIMITS**______________________
EFF DATE: __________ PRE-AUTH REQ: *YES NO* CONTRACTED: *YES NO* BEN GIVEN BY_______________
*Date Checked*: ____________

**SECONDARY Benefits**

DED: ______________ Remaining: _______________ OOP MAX: _____________ Remaining: ____________
PT PAID IN _________% OUT _________% CO-PAY_________ **POLICY LIMITS**______________________
EFF DATE: __________ PRE-AUTH REQ: *YES NO* CONTRACTED: *YES NO* BEN GIVEN BY_______________

Co-pay collection is: _________________________________________________________
**AUTHORIZATIONS / NOTES**
_________________________________________________________________________
_________________________________________________________________________

**THERAPIST:** ____________________ **Appt Date/Time:** _____________________________

## Medical History

Patient Name: ____________________ Age: _____ Height: ______Weight:_________

**Do you or have you had any of the following? Please circle Yes or No.**

| | | | | | |
|---|---|---|---|---|---|
| 1. Heart Failure | Yes | No | 17. Heart Disease or Attack | Yes | No |
| 2. Angina Pectoris | Yes | No | 18. High Blood Pressure | Yes | No |
| 3. Heart Murmur | Yes | No | 19. Rheumatic Fever | Yes | No |
| 4. Heart Pacemaker | Yes | No | 20. Congenital Heart Lesions | Yes | No |
| 5. Heart Surgery | Yes | No | 21. Stroke | Yes | No |
| 6. Emphysema | Yes | No | 22. Tuberculosis | Yes | No |
| 7. Asthma | Yes | No | 23. Chronic Bronchitis | Yes | No |
| 8. Breathing Problems | Yes | No | 24. Diabetes / Hypoglycmeia | Yes | No |
| 9. Cancer | Yes | No | 25. Chemotherapy | Yes | No |
| 10. Thyroid Problems | Yes | No | 26. Alcohol / Drug Abuse | Yes | No |
| 11. AIDS/HIV + | Yes | No | 27. Leukemia | Yes | No |
| 12. Epilepsy / Seizures | Yes | No | 28. Fainting or Dizzy Spells | Yes | No |
| 13. Rheumatoid Arthritis | Yes | No | 29. Osteoarthritis | Yes | No |
| 14. Sciatica | Yes | No | 30. Birth Defect / Amputation | Yes | No |
| 15. Sprain or Strain | Yes | No | 31. Skin Disease / Disorder | Yes | No |
| 16. Gout | Yes | No | 32. Eyes, Ears, or Throat disorders? | Yes | No |

Additional Comments (Please indicate question number)

_______________________________________________

_______________________________________________

List names & dosages of any medications you are currently taking.

_______________________________________________

_______________________________________________

**Please answer the following questions. For Yes questions, please give additional information on the lines provided.**

Do you have any condition or disease not listed? YES NO

_______________________________________________

_______________________________________________

Have you been under the care of a physician during the past 2 years? YES NO For What?

_______________________________________________

Do your ankles swell during the day? When you walk up stairs or take a walk, do you have to stop because of pain in your chest, or shortness or breath, or because you are very tired? YES NO

_______________________________________________

_______________________________________________

WOMEN: Are you pregnant now? YES NO How many month? _____ Is there a possibility that you are pregnant? YES NO

Have you ever had a sprain or strain? Have you ever had a broken bone? YES NO

_______________________________________________

_______________________________________________

Have you ever had physical therapy before? YES NO When and what for?

_______________________________________________

Have you ever had surgery before? YES NO When and what for?

_______________________________________________

_______________________________________________

*To the best of my knowledge, all of the above answers are true and correct. I understand it is my responsibility to inform the physical therapist of any changes.*

Signature: ________________________ Date: _________ Printed Name: ________________________

Therapist Signature: ____________________________________ Date: ___________________________

Patient: ______________________ Body Part: ____________

## Conditions and Consent for Physical Therapy

-I understand that I am a patient of Jarrett Orthopaedic Rehabilitation Inc. and I request and give consent to Jarrett Orthopaedic Rehabilitation Inc. (JOR) to provide and perform such therapeutic care, tests, procedures, and other services and supplies as are considered necessary or beneficial by my physician for my health and well being.

-In order for physical therapy treatment to be effective, I must come to my scheduled appointments unless there are unusual circumstances. Cancellation without 24 hours notice will result in a $50 cancellation fee. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

-I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

-I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize JARRETT Orthopaedic Rehabilitation, Inc., to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

-I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. JARRETT Orthopaedic Rehabilitation, Inc. will assist patients in obtaining insurance benefits when those benefits are assigned to JARRETT Orthopaedic Rehabilitation, Inc. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to JARRETT Orthopaedic Rehabilitation, Inc. In the case of default payment. I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

-The therapist provides a wide range of services and I understand that I will receive information at the initial evaluation concerning the treatment and options available for my condition. **Potential Risks:** I may experience an increase in my current level of pain or discomfort, or an aggrevation of my existing injury or condition. This discomfort is usually temporary; if it does not subside within 24 hours, I agree to contact my physical therapist. **Potential Benefits:** May include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. **Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

**I have read the above information and I consent to physical therapy evaluation and treatment.**

**Signature:** ____________________________ **Date:** ______________________

**Therapist Signature:** ________________________ **Date:** ________________

## To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Your referring doctor and therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure that you attend the prescribed number of treatments for the week.

- There is a $50 charge for cancellations without proper notice. This charge will NOT be covered by insurance, but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patient, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- You may need to see a therapist other than your primary therapist if you do reschedule your appointment. All of our therapists are experienced professionals and they will study your patient chart to ensure continuity of care.

- Please understand that your progress depends on your consistency with physical therapy. If you are experiencing discomfort or pain it is still recommended that you attend your scheduled therapy session as conservative treatment can be performed by your therapist along with applicable modalities.

When you do not show as scheduled, three people are hurt: 1) You, because you do not get the treatment you need as prescribed by your doctor and therapist, 2) Your therapist, who now has space in his schedule since time was reserved for you personally, and 3) another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We are looking forward to working with you.

I have read and understand this policy.

________________________________ ____________________

Patient Signature Date

By signing this form, you are acknowledging that you have received a copy of our *Notice of Privacy Practices*, and that you are granting consent for Jarrett Orthopaedic Rehabilitation Inc. to use and disclose your private health information for the purpose of treatment, payment, and healthcare operations. The *Notice of Privacy Practices* contains detailed information about how we may use and disclose your private health information. You have a legal right to review our *Notice of Privacy Practices* before you sign this consent, and we encourage you to read the notice in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.jorinc.com or contacting our office at 949-722-8811.

You have the right to request a restriction on how we use and disclose your private health information. This request must be specific and must be made in writing. If it is determined that it is not in our best judgment to do so, or if it would pose a potential risk or harm, or interfere with treatment, payment, or healthcare operations, we may be unable to grant your request. If there is not a written request with specific disclosure restrictions, it is understood that we will abide by the disclosure practices defined in the *Notice of Privacy Practices.*

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your personal health information in reliance on your consent.

Printed Name: ______________________________________

Signature: ________________________________________

Date: __________________

Per Health Insurance Portability and Accountability Act (HIPAA)    Valid 6 years from signature date

**Photography Consent / Release**

I, ____________________________________, hereby grant permission to Jarrett Orthopaedic Rehabilitation to take and use: photographs and/or digital images of me for use in news releases and/or educational materials. These materials might include printed or electronic publications, websites, or other electronic communications. I further agree that my first name may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Jarrett Orthopaedic Rehabilitation.

Signature: ________________________________________

Date: __________________

## Assignment of Benefits

Date: ______________________________

Patient: ____________________________

ID#: _______________________________

Policy/Group#:______________________

I hereby instruct and direct ________________________________ Insurance Company to pay by check made out to **Jarrett Orthopaedic Rehabilitation, Inc**. located at **2651 Irvine Ave. Suite 128, Costa Mesa, CA 92627.**

For the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed 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 also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Jarrett Orthopaedic Rehabilitation, Inc. to initiate a complaint to the insurance company for any reason on my behalf.

Dated at Jarrett Orthopaedic Rehabilitation, Inc., Costa Mesa, CA this ______ day of ___________20___.

Patient Signature:_____________________

Witness______________________________

Parent / Guardian, if patient is under 18yrs. of age:________________________

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## Cancellation Policy

Jarrett Orthopaedic Rehabilitation, Inc. requests our patients abide by our cancellation policy by allowing ***24 hours advanced notice*** of any cancellations. Should cancellations fall within 24 hours, the patient, **not** the insurance company, will be billed ***$50 per occurrence***, payable upon the next visit.

We ask that when scheduling any future appointments, please be considerate of other patients awaiting treatment and plan accordingly.

Patient Signature: ________________________________________