ARC Physical, Occupational, Hand and Speech Therapy Inc.

Patient Information and Registration

Name _____ Age _____ Birth Date _____ Sex _____
Home Address _____ City _____ Zip _____
Mailing Address _____ City _____ Zip _____
Email Address _____ Social Security _____
Phone- Home _____ Cell _____ Work _____
Emergency Contact _____ Emergency phone # _____
Referring Physician _____ Primary Care Physician _____
Have you received any therapy or home health services (including nursing care) in the past year? ☐Yes ☐ No _____
Occupation _____
Date of injury or episode? _____ Is this a work related injury? ☐Yes ☐ No
Auto accident or other personal injury with another party being liable? ☐Yes☐ No
Name of responsible insurance company? _____ Claim # _____
Adjuster _____ Telephone # _____
Do you have an attorney representing you? ☐Yes ☐ No Name _____
Telephone _____
Employer (if workers comp.) _____
Address _____ City _____ Zip _____
Do you need interpretive services? ☐ Yes ☐ No. Preferred language? _____
Name of personal insurance company (if episode not work related) _____
Insured name if other than self._____ Social Security # _____
Your relationship to insured? ☐spouse☐parent☐other Telephone of insured _____
Address_____ City_____ Zip _____

We will bill insurance companies on your behalf

Co payments are due at the time of service. Deductibles, co pay and any charges assigned to the patient are patient responsibility. We are happy to assist you in communicating with insurance carriers regarding benefits and eligibility. We will work tirelessly to provide required documentation which supports the treatment rendered and ensures payment. We cannot be responsible for the determination your insurance company might make regarding payment. Please know that if we call insurance companies on your behalf to get benefit information, the information we obtain for you may not be accurate. We do not certify as correct and cannot be responsible for information insurance company employees give us over the phone. Ultimately, it is your responsibility to understand your insurance benefits and agree to payment for services. Please note that insurance will NOT cover any services provided at ARC if home health services are being supplied during the same time frame. Please advise us if home health practitioners are coming to your home.

I understand and agree with the above declaration. I have read ARC's policy for patient confidentiality and it has been made available to me.

I authorize ARC to release information needed to process my claim to insurance companies, adjusters, 3rd party payors, or legal entities which may require medical information. I authorize my insurance company to make payment directly to ARC for therapy charges. I understand my referral diagnosis and I consent to treatment at ARC

Signature _____ **Date** _____

ARC Rehabilitation Services
Medical History and Screening Form

Answers to the following questions will assist the Therapist in providing a safe and effective treatment program.

Name _____ **Age**_____ **Referring Physician**_____.

Problem to be treated_____

_____

Have you had treatment for this problem before? Yes_____ No_____
Have you had surgery associated with this problem? Yes_____ No_____
If Yes, please list date and type of surgery_____

_____

Are you currently taking any medications? Yes_____ No_____

If Yes, please list all medications_____

_____

_____

Do you now have/or have had any of the following?

High Blood Pressure	Yes	No	Sensitive to Heat / Ice	Yes	No
Heart Attack	Yes	No	Allergies	Yes	No
Heart Disease	Yes	No	Hernia	Yes	No
Pacemaker	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Metal Implants	Yes	No
Headaches	Yes	No	Dizzy Spells	Yes	No
Kidney Problems	Yes	No	Balance Problems	Yes	No
Nervous Disorder	Yes	No	Vision Problems	Yes	No
Arthritis	Yes	No	Cancer	Yes	No
Pregnant	Yes	No	Respiratory Problems	Yes	No

Other_____

If Yes, on any of the above, please explain and give approximate dates_____

_____

_____

Do you participate in a regular exercise program? Yes_____ No_____

If Yes, please explain_____

List any other major illness or surgery that has occurred in the past year_____

_____

_____

Patient Signature_____ **Date**_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Welcome to ARC. We appreciate you choosing our clinic for your Physical Therapy, Occupational Therapy, Hand or Speech Therapy needs. We are sensitive to the confidential nature of the personal and healthcare information received and generated during the course of treatment at our clinic. We make every effort to comply with all Local, State, Federal and Professional mandates and regulations. The **Health Insurance Portability and Accountability Act (HIPAA)** regulates the use of medical information and requires us to disclose how we use your information and our mutual rights regarding the use of medical records.

PATIENT/CLIENT RIGHTS:

1. Right to access records we have, 2. Right to know of any disclosure of medical records outside the scope of the HIPAA allowance (please see ARC USE OF MEDICAL RECORDS listed below.) 3. Right to request amendments (corrections) of inaccuracies of records produced at ARC, 4. Right to copies of your records (additional charge may apply), 5. Right to request restrictions on the use of your medical record, specifically, the right to restrict access to your records by your insurance company when you elect to pay out-of-pocket for medical services. 6. Right to be informed if a breach of confidentiality occurs by ARC or any entity with which ARC has a business relationship. 7. Right to have your record accessed by family members in the event of your death. 8. Right to file a complaint. Please contact Dave Hammer, President of ARC Physical, Occupational, Hand and Speech Therapy, Inc., 805 434-4885 or contact the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 1-877-696-6775.
For more detailed information about HIPAA visit
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

ARC USE OF MEDICAL RECORD:

We may use your medical record and/or release your personal and heath care information in the following ways: 1. for Patient Treatment, 2. To facilitate normal operational activity of ARC; scheduling, treatment, billing, authorizations of service, medical consultation. 3. To obtain payment for services. Some insurance carriers contract with a third party to authorize services or process claims. We will comply with the requests of these third party administrators to facilitate treatment authorizations and payment of claims. 4. for emergency care, 5. when legally required in the case of a court ordered subpoena or a request regarding application for disability benefits. 6. to other persons or entities as requested in writing by you or to family members or emergency contact persons listed on your intake sheet.

We are required to demonstrate that we have informed you of these policies. Please sign below. **I acknowledge that I have been informed of my rights and of the ARC policy regarding use of my personal and medical information. I authorize ARC Physical, Occupational, Hand and Speech Therapy, Inc. to communicate with me regarding appointments via phone, fax or email and to leave messages, which may contain medical, insurance or personal information, on any numbers I have supplied to them.**

Signature_____ Date_____

Print Name_____ Revised: September 2013