

ARC Physical, Occupational, Hand and Speech Therapy Inc.

Patient Information and Registration

Name _____ Age _____ D.O.B _____ 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 or have any ongoing therapy or home Health services (including nursing care) in this calendar year? Yes No If so, where _____

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 _____ Phone# _____

Do you have an attorney representing you? Yes No Name _____

Phone# _____

Employer (if workers comp.) _____

Address _____ City _____ Zip _____

Do you need interpretive services? Yes No Preferred language? _____

Name of personal insurance company (if episode is not work related) _____

Insured name if other than self. _____ Social Security _____

Your relationship to insured? Spouse Parent Other

Phone# of insured _____

Address _____ City _____ Zip _____

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 _____

Date of injury or episode _____

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 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 how of any disclosure of medical records outside the scope of HIPAA allowance (please see ARC USE OF MEDICAL RECORDS listed below) 3. Right to request amendments (corrections) of inaccuracies of your records produced at ARC 4. Right to copies of your records (additional charges 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 Adam 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 health 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.

ARC Communication and Documentation Policy

We may use phone, text messaging, fax, or email to communicate with you.

By signing, I consent to receive SMS from ARC Physical Therapy, Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit https://arcphysicaltherapy.net/?page_id=5228 to see our privacy policy and our Terms of Service.

ARC Physical Therapy utilizes AI-assisted dictation software to support the documentation of clinical notes. By signing this document, I acknowledge and consent to the use of audio recording for note-taking purposes. This technology allows our providers to focus more fully on delivering high-quality, attentive care during treatment sessions. All recordings are used solely for documentation purposes and are handled in accordance with applicable privacy and confidentiality standards.

ARC Financial and Missed Appointment Policy

We will bill the insurance companies on your behalf. Copayments are due at the time of service. Deductibles, copays, and any charges assigned to the patient are patient responsibility. 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 provide 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.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed to ensure the most optimum results. It is expected that you keep all your appointments, except for illness or serious emergencies. We will assist in this by providing you with a calendar at the front desk of your appointment times. If you need to reschedule an appointment, we require a **24-hour notice**. In such a case please call our office and arrange a make-up appointment with our front desk. In the instance of cancellation without **24-hour notice**, we reserve the right to charge you a **\$25.00 fee**. In the instance of a **no-show**, you will be charged a **\$50.00 fee**. In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care. We will inform you physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly for choosing ARC Physical Therapy and strive to accomplish wonderful results and success for you.

ARC Physical Therapy has the capability to place a valid credit or debit card on file for patients receiving treatment. Card information will be securely stored and used only for authorized

purposes, including (1) recurring copays or coinsurance, deductibles and any insurance assigned patient responsibility (2) patient-approved payment plans, and (3) charges associated with repeated missed appointments or cancellations made less than 24 hours before a scheduled visit. All card information is stored in compliance with Payment Card Industry Data Security Standards (PCI-DSS) and applicable federal and state privacy laws, including HIPAA.

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, text message, 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: April 2025