

Financial Policy

The team at C.O.R.E. Physical Therapy by Bryan Pacillas is pleased to be part of your rehabilitation experience, and we thank you for choosing us. We believe that communication with our patients regarding our financial policy assists in providing the best service to you.

*****The American Medical Association recommends positive identification of all patients in an effort to prevent insurance fraud and identity theft. You will be asked to provide your Social Security number and phot ID for insurance purposes.*****

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to C.O.R.E. Physical Therapy by Bryan Pacillas medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

FINANCIAL POLICY:

Your insurance policy is a contract between you and your insurance company. We will need current and valid insurance information to accurately check your insurance plan with your insurance company. As a courtesy, we will file claims for those plans with which we have an agreement. If your insurance company does not pay within a reasonable amount of time, we will look to you for payment. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service is "not covered" you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage. **Payment in full unless otherwise arranged is due upon receipt of a statement from our office.** It is your responsibility to know your insurance benefits including, but not limited to, deductible and copay amounts that are contacted with your plan. It is also your responsibility to notify our office when your insurance plan or benefits change. Any costs incurred by this office because of incorrect information provided to us by you will be your responsibility.

*****We will gladly call your insurance company to obtain your current benefit coverage. However, insurance companies will not guarantee medical benefits or payment over the phone. We can only use this information as a guideline.*****

MINORS:

A parent or legal guardian must accompany a minor patient on his or her first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have a written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for payment of the services at the time of service.

I have read the Financial Policy and understand and agree to the above.

Signature: _____ **Date:** _____

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand C.O.R.E. Physical Therapy by Bryan Pacillas Notice of Information Practices. I understand that C.O.R.E. Physical Therapy by Bryan Pacillas may use or disclose my personal health information for the purpose 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 my treatment, payment and administrative requests for restrictions on a case to case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes noted in C.O.R.E. Physical Therapy by Bryan Pacillas Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practices in writing at this time.

Patient Name

Signature

Date

New Patient Information

We welcome you as a patient of C.O.R.E. Physical Therapy by Bryan Pacillas. To better serve you and to receive the maximum benefit of your treatment, it is extremely important to follow a few guidelines.

- A. All appointments must be kept as scheduled. Please call if you are unable to make you scheduled appointment 24 hours in advance. A non-visit charge may be added to your bill if you do not do so.**
- B. If you cancel more than 3 times, you may be discharged from physical therapy. Also, the only way we can help you recover, is to have you consistently participate with your treatment.**
- C. For each no show appointment, a fee of \$50 will be charged to your account. We will have to discharge you from physical therapy for repeated no shows.**
- D. Communication is a vital part of your treatment with C. O. R. E. Physical Therapy by Bryan Pacillas. Please make us aware of any questions or concerns you have while treating with us. Also, communicate your status and quality of care with your referring doctor.**

Signature_____ **Date**_____

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION: This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981. Section 56et. Seq. California Civil Code.

AUTHORIZATION:

I hereby authorize _____,
(Name of Healthcare Provider/Physician)

To furnish to C.O.R.E. Physical Therapy by Bryan Pacillas medical records and information pertaining to medical history, physical condition, services rendered, or treatment for _____ and _____
(Name of patient) (Date of Birth)

This authorization is limited to the following records and type of information: All medical records.

USES: The requestor may use the medical records and type of information authorized only for the following purposes: Medical evaluation and care.

DURATION: This authorization shall become effective immediately and shall remain in effect until for 1 year.

RESTRICTIONS: I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless disclosure is specifically required/permitted by law.

SIGNATURE: _____ **Date:** _____

CORE Physical Therapy by Bryan Pacillas pc
1136 N. Chinowth Visalia, CA 93291
Phone#(559) 671-0101 Fax#(559) 590-4301
Bryan Pacillas, MPT

I hereby acknowledge that I can receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: _____ Date: _____

Print Name: _____ Date: _____

If not signed by the patient, please indicate:

Relationship:

- Parent/guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary/personal representative of deceased patient

Name of Patient: _____

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

First

MI

Last

(Circle One) Male or Female

(Circle One) Married or Single

Date of Birth ____/____/____ **Age:** ____ **SS#** _____

Address: _____ **CA** _____

Street

City

Zip Code

Home Phone # () _____ **Cell Phone #** () _____

Work Phone # () _____ **Employer:** _____

Email Address: _____

1st Emergency Contact Name: _____

Last

First

1st Emergency Contact Phone # () _____

2nd Emergency Contact Name: _____

Last

First

2nd Emergency Contact Phone # () _____

***Referring Doctor:** _____ **Family Doctor:** _____

(Circle One) My Condition is related to: **Work** **Auto Accident** **Other:** _____

*Consent to release Medical Records: I hereby authorize the release of my medical records for the use in my medical treatment. I understand that I have the right to consent to, authorize, agree with, or object to any certain uses or disclosures of my protected health information, as well as to request privacy protection for my protected health information. I understand that in signing this record release that it can be revised by me (the patient) or the Provider of Services, in order to protect my privacy. Medical records may be used to aid in my medical care and insurance purposes. Insurance companies can request medical records, and may be released for 1 year from the date of my signature.

Patient/Parent Signature: _____ **Date:** _____

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Name: _____ **Age:** _____ **Dominant Hand: R or L**

Sex: M or F

Employer: _____ **Occupation:** _____

When did your injury/condition occur? (Date) _____

What body part(s) are currently painful? 1. _____ 2. _____
3. _____ 4. _____

Describe how the injury happened: _____

What are your current complaints/difficulties? _____

Please mark what treatments have you already received for this condition?

Physical Therapy _____

Chiropractic _____

Surgery ___ **Date** _____

CT Scan ___ **Date** _____

EMG/NCV ___ **Date** _____

MRI ___ **Date** _____

X-Ray ___ **Date** _____

None _____

What Medications are you taking for this condition?

1. _____ x day a.m./p.m.
2. _____ x day a.m./p.m.
3. _____ x day a.m./p.m.

General Health: Good_____ Diabetes_____ High Blood Pressure_____

Hobbies/Activities: _____

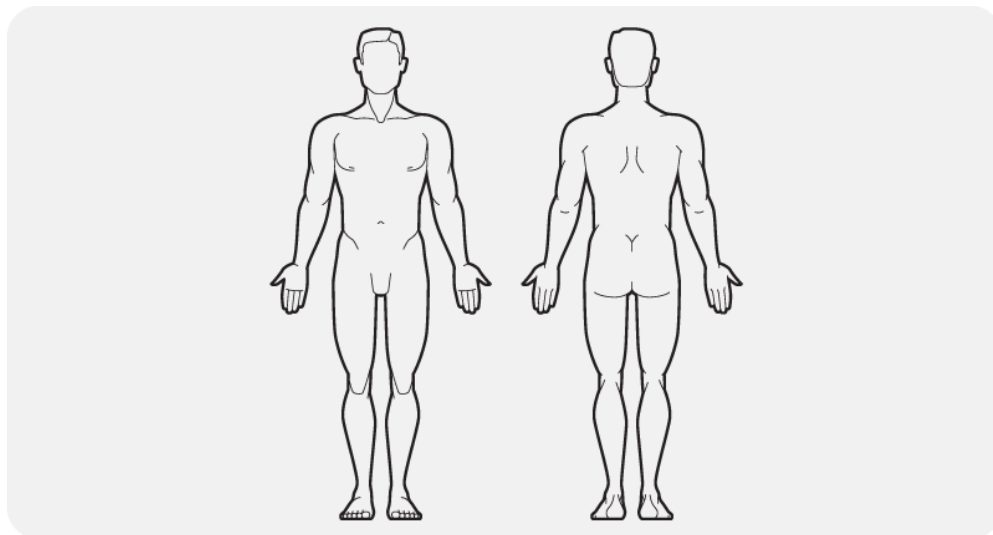
1. Are you currently working? Yes____ No____
2. Do you have any work limitations? Yes____ No____

If yes, list limitations _____

3. Have you had any previous work related injuries other than the current one? Yes____ No____

If yes what body part and when?

Mark the picture where you have pain or symptoms: // =Numbness ++ =Tingling/Burning XX =Ache
SS =Soreness OO =Pain



CORE Physical Therapy by BRYAN PACILLAS pc

CONSENT FORM FOR TEXT MESSAGING REMINDERS

I give permission consent to receive text messages from CORE Physical Therapy by Bryan Pacillas pc or others acting on the CORE Physical Therapy by Bryan Pacillas pc behalf. As part of this consent, You represent and warrant the following:

- (1) CORE Physical Therapy by Bryan Pacillas pc or others acting on their behalf may send text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders.
- (2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.
- (3) You are solely responsible for any message and data charges associated with such text messages.

If You do not wish to receive text messages from the CORE Physical Therapy by Bryan Pacillas pc or others acting on their behalf, You should not sign this form.

Printed Name

Date of Birth

Signature

Mobile Phone Number