PETZOLDT MEMORIAL HAND & PHYSICAL THERAPY
4010 MOORPARK AVENUE, SUITE 103 PHONE: 261-7660 FAX: 246-1574

PATIENT INFORMATION Clinic Number ____________________

Name (Last) ____________________ (First) ____________________
(El Nombre del Paciente) (Apellido) (Primero)

Home Address ____________________
(Numere y la Calle, Estado, y Codig)

Phone Work # ____________________ Home ____________ Cell ____________
(Telofono de trabajo , casa, y celular)

Date of Birth ____________________ Social Security Number ____________________
(La Feche de Nacimiento) (El Numero del Seguro Social)

Employer Name ____________________ Address ____________________
(El Nombre de Uonde Trabajas)

Occupation ____________________
Trabajo)

EMERGENCY NAME : ____________________ **PHONE#** ____________________

MEDICAL INFORMATION

Referring Doctor ____________________ Doctor Phone ____________ Fax ____________
(Nombre del Doctor que lo Refirió a esta Oficina)

Diagnosis ____________________ Date of Injury ____________________

Surgery ____________________ Date of Surgery ____________________

Date of Prescription ____________________ Treatment ________ x Per Week ________ Weeks

INSURANCE INFORMATION Is this a Worker's Comp claim? YES (si) NO (no)
(Es éste un accidente reladionado con su trabajo?)

Insurance Company ____________________ Claim or ID Number ____________________
(compania de Seguro*) (Numero de Identificación)

Workers Compensation Adjuster or Case Manager ____________________

Insurance Phone ____________________ Insurance Fax ____________________

Insurance Address ____________________

Utilization Review (UR) Phone: ____________________ Utilization Fax ____________________

Attorney ____________________ Phone ____________________

Petzoldt Memorial Hand & Back Rehab

4010 Moorpark Avenue Suite 103, San Jose CA 95117 Phone: 408-261-7660 Fax: 408-246-1574

Fax

To:		**Date:**	
Fax:		**Phone:**	
Patient:		**Claim #**	
From:		**Fax/Phone**	408-246-1574 / 261-7660
CC:		**Fax:**	
Total # of Pages:			

URGENT Please SIGN Please AUTHORIZE For REVIEW Please REPLY

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal Law. Warning: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.

PETZOLDT MEMORIAL HAND & BACK REHABILITATION
4010 MOORPARK AVENUE SUITE 103 SAN JOSE CA 95117 PHONE: 408-261-7660 FAX: 408-246-1574

MEDICAL QUESTIONNAIRE

_____________ Name: ______________________________________
Medical Record #

1. Do you experience any of the following when nervous, excited, walking or engaged in vigorous work?

   Chest Pain: No _____ Yes _____
   Palpitations: No _____ Yes _____
   Breathing Difficulties: No _____ Yes _____

2. Please list any medications you are currently taking (Attach a separate sheet if necessary)

   ____

3. Do you have or have you ever had:

   Angina: No _____ Yes _____
   Stroke: No _____ Yes _____ If Yes, when? ____________________________________
   Heart Attack: No _____ Yes _____ If Yes, when? ____________________________________
   Diabetes: No _____ Yes _____
   Known Cancer: No _____ Yes _____ If Yes, give date of surgery _______________
   Back Problems: No _____ Yes _____

4. Are you Pregnant? No _____ Yes _____ N/A _____
5. When was your last physical exam or visit with a doctor regarding your GENERAL health?

6. Are you allergic to any medications? No _____ Yes _____ If Yes, please list:

   ____

7. Do you have any other medical condition(s) that we should be aware of?

   No _____ Yes ______ If Yes, please list : ____

   ____

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FINANCIAL AGREEMENT

______________ Name: ____
Medical Record #

Thank you for choosing Petzoldt Memorial Hand & Back Rehab as your health care provider. We are committed to providing you with the best possible care and look forward to helping you with your recovery.

Please read the following Appointment and Financial Policy. If agreed, please Initial, where indicated and sign at the bottom. THANK YOU.

1. **Petzoldt Memorial Hand & PT is IN _____ my provider network NOT IN _____ my provider network. (subject to verification) Note: we are not Contracted with SCIPPA INITIAL ______**

2. **Petzoldt Memorial Hand & Physical Therapy will bill your insurance company as a courtesy. If there is a denial of payment by the insurance company you are responsible for making the full payment directly to our clinic within 30 days. Balances not received within 30 days may be sent to a collection service.**
   INITIAL ______

3. **I understand that my co-payment or co-insurance is an <u>estimate only</u> and that I may owe a balance at the end of the treatment. If your deductible has not been met you will be required to pay in full for the visits up to the amount of the deductible. After the deductible has been met the regular copay per visit becomes applicable. Deductible: _____________ Met Not Met as of ______________**
   INITIAL ______

4. **I agree to pay the estimated co-payment/Co-Insurance amount of $_________ per treatment. Copayments are usually stated on the front of your insurance card. Verification of the copay amount and coverage will be made by office staff on all insurance. INITIAL ______**

5. **I understand that if a balance is due at the end of treatment, I have 30 days to pay.**
   INITIAL ______

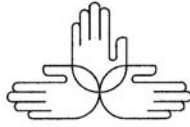
6. **I agree to provide at least 24 hours advanced notice of any cancellations. INITIAL ______**

7. **I will pay $30 for all appointments cancelled or missed without 24 hour notification.**
   INITIAL ______

8. **<u>RE. SCIPPA – We are NOT contracted with SCIPPA HMO, or any HMO (except Kaiser)</u>**
   INITIAL ______

Patient Signature: ______________________________________ Date: ________________

We Accept Visa, Master Card, Personal Checks and Exact Cash



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NO SHOW / CANCELLATION POLICY

We make every effort to make your appointments convenient and consistent. Please let us know if you have any specific preferences and we will try our best to accommodate your schedule.

For our Workers Compensation Patients:
Please be informed that Petzoldt Memorial Rehab is required to notify your insurance company in the event of more than 1 No-Show or 2 Cancellations. Future appointments may not be scheduled and existing appointments may be cancelled.

For All Patients:
We ask for 24 hours notice for cancellation or modification of existing appointments. This allows us to schedule other patients who may be waiting for an appointment.
A $30 charge is assessed for appointments cancelled after this time period.

We understand emergencies and unforeseen events do occur; please let us know as soon as possible of any changes.

Thank You!

Please sign below to indicate you have read this policy.

Signed: ____

Date: ____

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RECORDS RELEASE AUTHORIZATION

Date: ___________________________

To: Petzoldt Memorial Hand & Physical Therapy
1062 Saratoga Avenue
San Jose, CA 95129

I hereby authorize Petzoldt Memorial Rehab to discuss my case, release records and request records from the doctor or referral source, listed below
To/ From

____

____

____

Signed: ____
(Patient or Relative)

Witness: _______________________________________

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 -- Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________