HealthWest
PHYSICAL THERAPY

Initial Adult Intake Form

Date Referral: _____/_____/_____
Name of Patient: _____ GENDER: ___ DOB: ___/___/____
Referred By : _____

Date of accident / onset of injury/disease: _____/_____/_____
Address: _____
Phone Number: _____ Email: _____
Primary Diagnosis and Presenting Conditions:

_____

_____

Precautions/ Medications:

_____

Reason For Referral/ Treatment Prescription (Frequency and Duration):

_____

Equipment Currently Used:

_____

Physician Name: _____ Phone Number: _____
Prescription Received: _____

BILLING INFO: ___ PPO ___WC ___ Private Insurance ___ Cash Pay ___ HMO
Social Security Number: _____/_____/_____
NAME OF INSURANCE CARRIER: _____
ADDRESS:_____
Insurance Policy Number: _____
Claim / Group or Authorization: _____
Name and DOB of Insured if Other than Patient: _____

Current Medications: _____
Additional Info: _____

Emergency Contact Name and Number: _____

HealthWest THERAPY

Informed Consent for Telehealth Therapy Service

PATIENT NAME: _____

LOCATION OF PATIENT : _____

DOB: _____/_____/_____

PROVIDER NAME: _____

ADDRESS: _____

DATE CONSENT DISCUSSED: _____/_____/_____

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to HEALTHWEST THERAPY providing Physical Therapy services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for:
____ full payment of my telehealth visits.
____ copayments or coinsurances that apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting HEALTHWEST THERAPY at 760-704-7000. As long as this consent is in force and has not been revoked HEALTHWEST THERAPY may provide health care services to me via telehealth without the need for me to sign another consent form.

_____

Signature of Patient/Guardian Date

_____

Signature of Witness Date

HealthWest PHYSICAL THERAPY 1482 La Mirada Drive San Marcos, CA 92078

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for JG Performance Fitness, Inc., doing business as Healthwest Therapy, to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical condition.

AUTHORIZATION BENEFIT ASSIGNMENT – FINANCIAL RESPONSIBILITY – RELEASE OF INFORMATION

I authorize Healthwest Therapy to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Healthwest Therapy from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Healthwest Therapy and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that I will make payments on the date of service, unless other arrangements have been made and a separate financial payment contract exists between Healthwest Therapy and me.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Healthwest Therapy to release all information necessary, including medical

---

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Healthwest Therapy Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Healthwest Therapy to use and disclose my protected health information to carry out treamtne, payment activities and health care operations. I understand the terms of this notice may change with time and Healthwest Therapy will always post the current notice at the clinic and have copies available for distribution.

Indicated below are individuals whom Healthwest Therapy may speak to regarding my treatment. Please list names.

Spouse _____ Father _____

Mother _____ Other _____

Listed below are individual(s) whom I request restriction regarding my protected health information.

Not Applicable

Other _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone number(s) you provide us?

Yes _____ Home Mobile Work Other _____

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care nd Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient/Guardian/Responsible Party Signature _____

Date _____

HealthWest THERAPY

Financial Policy

Patient's Name (Please Print) _____
DOB ___/___/____

□Accept Assignment _____ □Not Accept Assignment _____

□Medicare □Self-Pay

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, American Express, Discover, debit cards, cash and checks. The patient is obligated to pay for late cancellation fee/no show fee/fee for arriving late/ non-sufficient funds fee, and these particular fees cannot be billed to any insurance companies.

Cancellation Fee (less than 24 hours) $35
No Show Fee $35
Non-Sufficient Funds Fee $30
Canceled/Stopped Check Fee $30
Late fee (for each 15 minutes) $15

Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior authorizations. It is the patients' responsibility to know their physical therapy benefits, check with their insurer if the prior authorization is required and to follow up with our office if it was obtained & visits were approved.

Accept Assignment Patients: We have made prior arrangements with some insurance companies to accept an assignment of benefits. As a service to you, we will file your insurance claim if you assign the benefits to Beyond Basics – in other words, you agree to have your insurance

company pay us directly.

I agree to make immediate co-insurance and deductible payment upon receipt of services rendered. If HealthWest Therapy doesn't get reimbursed from my insurance company within 30 days from date of service, I will be financially responsible for the full remaining balance. If my insurance issues me the checks because HealthWest Therapy is an out-of-network provider, I am responsible to assign them to HealthWestTherapy. If my insurance company determines that my visits are (were) not medically necessary, I am responsible to pay the full fee for my treatments.

Not Accept Assignment Patients: If you are insured by a plan that we do not have prior arrangement with, we will prepare and send the claim for you in an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due in full at the time of service.

I agree to make immediate payment upon receipt of services rendered. I understand that my insurance forms will be submitted electronically/mailed from HealthWest Therapy so that I may get reimbursed. I also have the option of mailing out the insurance forms myself so that I may get reimbursed. It is also my responsibility to follow up on my reimbursements with my insurance company.

Private Patients: *Payment is expected at the time of service. Upon request, we will give you a paid bill to submit to your insurance company so that you can attempt to get reimbursed in part or in full. With your permission, we will cooperate fully with your insurance company if they request copies of treatment notes or other information related to the processing of your claim. Please note that we cannot make any representation that your insurance company will reimburse you in part or in full for our services, and payment to us in full is required regardless of the final determination of coverage by your carrier.*

IF ANY PAYMENTS ARE OVERDUE BY 60 DAYS, UNCOLLECTED FUNDS WILL BE SENT TO OUR COLLECTION AGENCY AND COLLECTION /PROCESSING/ATTORNEY/ COURT FEES WILL BE ADDED. ALL INVOICES SHOULD BE DUE AND PAYABLE TO HEALTHWEST THERAPY WITHIN 30 CALENDAR DAYS. PATIENTS WILL BE RESPONSIBLE TO PAY 10 % LATE FEE OF A MONTHLY INVOICE AMOUNT.

I HAVE READ AND UNDERSTOOD HEALTHWEST THERAPY'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient/Guardian Signature Date

HealthWest
PHYSICAL THERAPY

Billing and Cancellation Procedures

Charges for services that are provided by HealthWest Therapy are based upon the procedures that are deemed necessary by the therapist and physician to enable the patient to reach their goals. The patient is responsible for the payment of all fees regardless of whether the patient has insurance coverage for all or part of the bill. If the patient does have insurance that will pay for a portion or all of the service, HealthWest Therapy will bill the insurance company with the understanding that the patient provides all the necessary information, including but not limited to, a claim number, insurance card and a signed insurance form.

FEES and EXPENSES

1. Initial Evaluation - The charge for this is calculated on an hourly rate; rates can be pro-rated should an evaluation last longer than one hour.

2. Time sensitive direct therapy services – These can include such services as therapeutic exercise, massage, traction, kinetic exercises and activities. Charges for these services are based on one to one treatment time and are billed in 15 minute increments.

3. Modalities – This can include but not be limited to ultrasound, hot packs, electric stimulation, cold packs etc. There are separate charges for these services which may be performed by the primary therapist and in some instances a therapy aide or assistant.

Fees are reviewed on an annual basis, and HealthWest Therapy reserves the right to adjust the fees when it is deemed necessary. Thirty day advance written notification will be provided if any fee increase is instituted.

BILLING FOR SERVICES RENDERED

All bills for services rendered will be sent out to the insurance carrier within thirty days of the service performed. Any co-payment, co-insurance, or deductible is due at the time of service. For patients paying out of pocket, payment is expected at the time of service unless other arrangements have been made. All invoices unpaid after 45 days will be subject to the maximum interest penalty/finance charge allowed by law. HealthWest Therapy reserves the right to cancel treatment if payment for services is not received, and to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment.

Signature of patient Date

HealthWest THERAPY

Updated HIPAA Compliance Form - Notice of Patient Privacy Practices and Rights

This notice describes how medical information about you may be disclosed and used, and how you can get access to this information. Please read carefully.

Your basic rights and our basic responsibilities under HIPAA. Patients of this practice have the right to obtain a copy of paper or electronic medical records, make corrections to the record, request confidential communication, request that we limit the information we share, get a list of entities with whom we have shared your information, get a copy of this notice, choose someone to act on your behalf, and file a complaint if you believe your privacy rights have been violated.

Get a copy (paper or electronic) of your records. We will provide a copy of your record and can charge you a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect.

Request preferred confidential communications. You can ask us to contact you by a preferred method (i.e. home/office/cell) or ask to send mail to a specified address.

Limit what we share or use. You can ask us not to share or use certain health information for our operations, treatment or payment, although we are allowed to refuse your request if it would affect your care. If you pay for a service out of pocket in full, you can ask us not to share that with your health insurer, and we will comply unless a law requires us to share that information.

Get a list of those with whom we have shared information. Upon request you are entitled to receive a list of the times we have shared your health information, who we shared it with, and why for up to six years prior to the date you asked. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures, such as any you requested. There is no charge for a yearly request of this list, but there is a reasonable cost based fee if such list is requested more than once in a 12 month period.

Get a hard copy of this privacy notice. Upon request, you can receive a paper copy of this notice, if you have previously received this electronically.

Choose someone to act on your behalf. If someone is your legal guardian, or has medical power of attorney for you, that person can exercise your rights and make choices about your healthcare information. We will verify that any person has the authority to act on your behalf before taking any action.

File a complaint if you think your rights are violated. If you feel your rights have been violated, please contact us (info on page 1). You can file a complaint with the US Dept of Health and Human Services Office of Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/, calling 877.696.6775 or writing to: US Dept of H and H Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Your basic choices and our basic responsibilities under HIPAA. For certain health care information, you can tell us your choices about what we share. You can tell us whether to share information with your family, close friends, others involved in your care. You can tell us whether to share information in a disaster relief situation. We will never share your information for the sale of the information or for marketing purposes unless we have express written permission. We can contact you in the case of fundraising, but you can tell us not to contact you again.

Our use and disclosures of your health information to treat you, run our practice or bill for your services. We may use and share your health information to treat you and share with others who are treating you. Ex – a child being treated by multiple therapists and disciplines. We can use and share your health information to run our practice, improve your care and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities. Ex- we give information to your insurer so they will pay for our services.

Other ways we may share or use your health information. We are required (upon request) to share your information in other ways that contribute to the public good, such as public health and research. These conditions are stringent and regulated by many laws before any information can be shared.

Help with safety and public health issues. We can share health information about you for certain situations such as preventing disease, helping with product recall, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, preventing or mitigating a serious threat to someone's health or safety.

Do research. We can use or share your information for health research.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share information upon request when an individual dies.

Comply with the law, respond to any legal action. We will share information about you if state or federal law requires it, including any audits conducted by the Dept. of Health and Human Services. We can share information about you in response to a court or administrative order or in response to a subpoena.

Comply with worker's compensation, law enforcement, and other gov't requests. Information about you can be shared for worker's comp claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Blue Button protocol. Any patients with medical care managed by the Blue Button protocol can learn more about access to their health information at http://www.hhs.gov/digitalstrategy/open-data/introducing-blue-button-plus.html

Summary of our responsibilities. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will give you a hard copy of this notice and follow the duties and privacy practices described in this notice. We will not use or share your information other than as described here unless you tell us we can in writing that we can. You may also change your mind at any time and let us know in writing if you do. Add't info is available at: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website and in our office.

Effective date: 07/01/2020 **Privacy Officer:** Gwendolyn Alden **Phone:** 760-704-7000