Santa Maria Valley
PHYSICAL THERAPY GROUP

Todd Martin PT Jared Bailey PT Samantha Stollberg PT, GCS
Tom Meenzhuber PT John Hollinshead PT John Hinds PT
Karen Bailey PT Adrian Asencio OT R/L, CHT

OFFICE POLICIES AND PATIENT RESPONSIBILITY

- Treatment hours are Monday through Friday 7:00am to 6:00pm. We schedule our last appointments of the day at 5:00pm. Most days we are open through the lunch hour, however, there may be times we close.
- 4:00 and 5:00 appointment times are reserved for those patients who are working and cannot schedule earlier appointments.
- Co-payments are due at the time of service unless other arrangements have been made.
- Patients are brought in for treatment as their therapist becomes available. We do not necessarily bring patients in on a “first come first serve” basis.
- We understand that there may be rare instances when you have a good reason for being late, arriving late is unfair to your therapist and to the patient who has the appointment following yours. We will make an effort to complete some portion of your scheduled treatment plan. Repeated tardiness for appointments will result in a schedule change or counseling by your therapist.
- We ask that you do not arrive early for appointments due to the fact that our therapists are booked with appointments every hour of the day. You cannot arrive early assuming that they will be able to take you in for an appointment.
- If at all possible please try to give us 24-hour notice if you are unable to attend your scheduled appointment.
- If you have not shown for two consecutive appointments, without calling, we will automatically remove your name from further scheduled appointments.
- We ask that parents arrange for childcare while attending physical therapy treatments. We have limited room in gym areas and there are potential safety hazards for young children. If you are unable to arrange for childcare have your children wait in the front lobby or if older children please have them wait in your car. At no time are children allowed on the equipment. It is the responsibility of the patients to control their children and be sure they behave while at our facility.
- We respectfully request that you do not bring visitors to your visits. Because our treatment space is limited, visitors are a distraction to you and other patients.
- We respectfully request that you do not use a cell phone during your treatment this should be a time that is devoted to your rehabilitation without interruptions if at all possible.
- For workers compensation patients, if you frequently miss your appointments your doctor and/or case adjuster will be notified.
- To protect your identity we will request photo identification.

Santa Maria Valley Physical Therapy Group
NOTICE OF PATIENT INFORMATION PRACTICES

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

SANTA MARIA VALLEY PHYSICAL THERAPY GROUP'S LEGAL DUTY

Santa Maria Valley Physical Therapy Group is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Santa Maria Valley Physical Therapy Group uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Santa Maria Valley Physical Therapy Group may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Santa Maria Valley Physical Therapy Group may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Santa Maria Valley Physical Therapy Group policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Santa Maria Valley Physical Therapy Group may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Santa Maria Valley Physical Therapy Group will consider all requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Santa Maria Valley Physical Therapy Group may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Santa Maria Valley Physical Therapy Group health information practices or if you have a complaint, please contact the following person: Tom Meenzhuber.

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PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM

NAME: _____ Male/Female Date: _____

Address: _____
Street City State Zip

Phone: Home- _____ Cell: _____

Social Security Number: _____ Birthdate: _____ Age: _____

Do you want to be e-billed? **Y N** Email address: _____

Emergency Contact Person: _____ _____ _____
Not living with patient Name Relationship Phone

Name of Parent or Spouse: _____

Language of preference: English/Spanish/Other _____

Responsible Party/Parent/Guardian Name: _____

Phone: Home-_____Cell:_____Work: _____

Address:_____
Street City State Zip

EMPLOYMENT

Employer: _____ Job title: _____

Address: _____ Phone: _____ Ext: _____

Can we call you at work if necessary? Y N Are you currently working? Y N

Parent/spouse employer:_____

INSURANCE INFORMATION

TYPE: Private _____ Medicare _____ Worker's Comp _____ Other _____
Specify

Primary Insurance Company: _____

Address: _____ Phone: _____

Claims adjuster: _____ Claim No. or ID No: _____

Attorney: _____
Name Address City State Phone Number

PHYSICIAN

Primary Care Physician: _____Referred by:_____

Date of injury/surgery:_____ Date of next doctor visit?_____

Any previous PT for current problem? Yes No What was done/what was outcome? _____

Any chiropractic treatment? Y N Number of visits: _____ Any other form of treatment: _____

_____

Any previous injury to this area? Y N Was this a work related injury? Y N Is case open/closed?

Have you had Physical or Speech Therapy this year? Y N With Whom: _____ Have you had or are you having Home Health? Y N If yes with whom: _____

What was Home Health discharge date?: _____

HISTORY

Do you have/or have you had any of the following:

High Blood Pressure (reading ___/___)	Yes No	Sensitive to ice/heat	Yes No
Heart Disease	Yes No	Allergies	Yes No
Heart Attack	Yes No	Hernia	Yes No
Pacemaker	Yes No	Seizures	Yes No
Diabetes	Yes No	Metal Implants	Yes No
Headaches	Yes No	Dizziness/vertigo	Yes No
Nervous/Psychological Disorder	Yes No	Cancer	Yes No
Hearing Problems	Yes No	Incontinence	Yes No
Asthma/Respiratory Problems	Yes No	Neurological Disorder	Yes No
Tuberculosis (Year _____)	Yes No	Osteoarthritis/Osteoporosis	Yes No
Currently pregnant _____months	Yes No	Smoker	Yes No
Active Infections _____	Yes No	AIDS	Yes No
		Hepatitis A/B/C	Yes No

Other: _____

If yes to any of the above please explain & give approximate date:

_____

Past surgeries: _____

Medication(s) List: _____

_____

What is your occupation & physical requirements of job: _____

_____

Do you have difficulty with any of the following activities? (Check all that apply & specify distance, time, etc limits)

Standing _____ Sleeping _____ Sitting _____

Walking _____ Driving _____ Lifting _____

Personal Care _____ Other _____

What benefits do you expect to gain from physical therapy? _____

_____

The above information is correct to the best of my knowledge.

I have read and fully understand Santa Maria Valley Physical Therapy Group (SMVPT) Notice of Information Practices. I understand that SMVPT may use or disclose my personal health information for the purposes 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 treatment, payment, and administrative operations if I notify the practice. I also understand that SMVPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in SMVPT Notice of Information Practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing at any time.

I hereby authorize my insurance company to pay directly to SMVPT medical benefits otherwise payable to me. I understand that I am responsible for all charges regardless of insurance coverage.

I authorize SMVPT to contact former providers of physical therapy for information regarding Medicare payments pertaining to the Medicare cap.

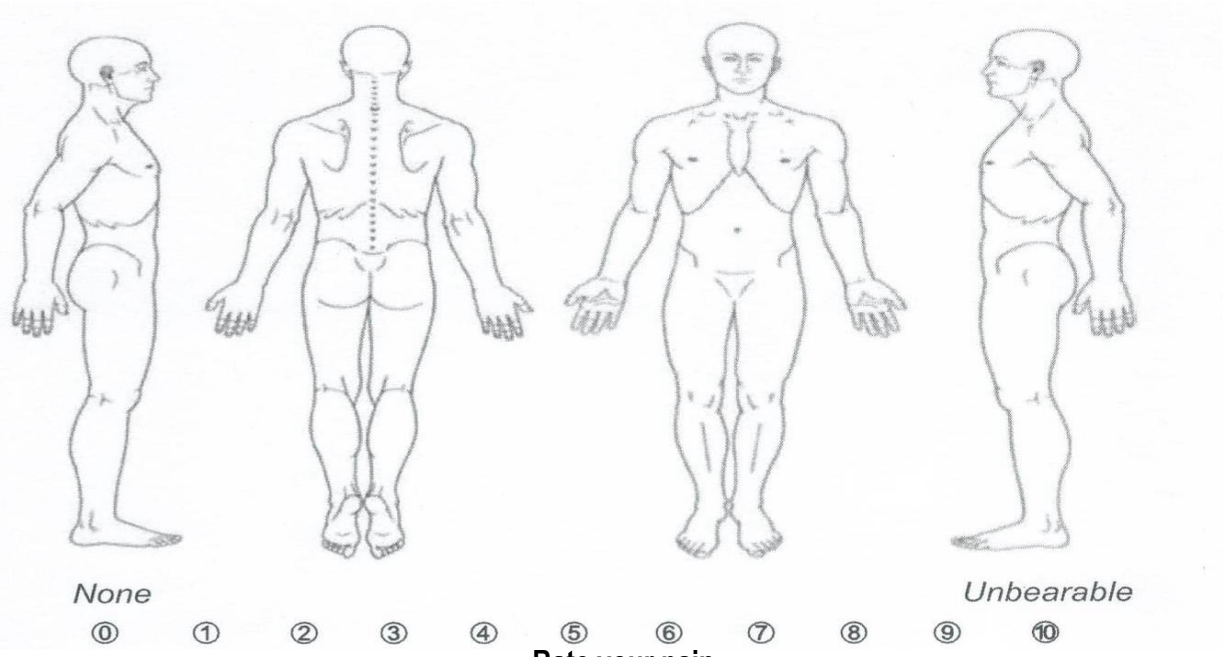
Signature: _____ Date: _____

SHORT-FORM PAIN QUESTIONNAIRE
Ronald Melzak

Patient name: _____ Date: _____

	None	Mild	Moderate	Severe
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Hot-Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring-Exhausting	_____	_____	_____	_____
Numbness	_____	_____	_____	_____

Please indicate location of pain:



Rate your pain

Medical Release Form

If you have had medical testing (X-rays, MRI, etc.) or surgery related to the current diagnosis, please PRINT your name below so that we may review these reports.

Patient Name: _____

Date of Birth: _____

Place of service: _____

You are hereby authorized to release to Santa Maria Valley Physical Therapy Group the report(s) requested below.

_____ _____

Signature Date

Report requested: _____

_____

_____

DATE OF SERVICE: _____

Please fax the requested report(s) to (805) 349-7206 or mail to Santa Maria Valley Physical Therapy Group
820 East Enos Drive, Santa Maria, CA 93454

Santa Maria Valley Physical Therapy Group Inc.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Patient Signature: _____

Date: _____

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CREDIT CARD PRE AUTHORIZATION FORM

I authorize **SANTA MARIA VALLEY PHYSICAL THERAPY GROUP** to keep on file and to charge my debit/credit card for any services provided to _____ as specified below.

Please initial each line showing you have read and understand.

____ Fees for services not paid by guardian, patient, or patients insurance within 90 days.

____ Co-pays not paid at the time service was rendered.

____ Balance of any charges that were not covered by patients insurance.

Name of patient: _____

We will bill your insurance as a courtesy to you, however, you are responsible for the total payment regardless of any denial or partial insurance payments.

Terms of Agreement: Santa Maria Valley PT Group reserves the right to refuse or terminate your automatic credit card payment services. This agreement is to remain in effect until Santa Maria Valley Physical Therapy Group terminates it or receives written notification of its termination and has sufficient time to act on it.

Patient Name: _____

Cardholders Name (as it appears on card: _____

Cardholders Billing Address: _____

_____

☐ Visa ☐ Mastercard ☐American Express ☐ Discover Card

Credit Card Number: _____

Expiration Date: _____ CV#: _____

820 East Enos Drive Santa Maria, CA 93454 (805) 928-8257 FAX (805) 349-7206 www.smvpt.com