



How did you hear about our office?  Doctor  Family/Friend  Google  Community Event  Other: \_\_\_\_\_

**PATIENT INFORMATION**

**PLEASE COMPLETE FORM LEGIBLY**

Date: First Name: Last Name: Middle Initial:
Address: Appt Reminders: Phone Call Text Message Email
City State Zip
Date of Birth: Male Female S.S. #:
Email: Home Phone:
Mobile Phone: Work Phone:
Employer: Occupation:
Employment Status Full Time Part Time Retired Not Employed

Work Address:
City: State: Zip:

**SPOUSE / GUARDIAN INFORMATION**

Name: Relationship to Patient: DOB:
Employer: Work Phone: ( )

**CARE PROVIDER INFORMATION**

Referring MD: Referring MD Phone: ( ) -
Primary Care MD: Primary MD Phone: ( ) -

**INSURANCE INFORMATION ( PLEASE GIVE INSURANCE CARD(S) TO THE FRONT DESK )**

Please Mark Primary Insurance/Payment Type:  Work Comp  Auto  Private  Medicare  Cash :

Primary Insurance Name:
ID. #: Group #:

SUBSCRIBER'S NAME (IF DIFFERENT): Birth Date: / /

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other:

Name of Secondary Insurance:
ID. #: Group #:

Subscriber's Name: Birth Date: / /

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other:

**AUTO CLAIM ( PLEASE PROVIDE YOUR HEALTH INSURANCE INFORMATION FOR BACKUP )**

Insurance Name : Phone:
Adjuster/Claim Manager: City State:
Address: Accident Date: / / Cause:
Claim #:

**IN CASE OF EMERGENCY**

Contact Name: Primary Phone: ( ) - Work Phone: ( ) -
Relationship to Patient:  Spouse  Parent  Sibling  Other: \_\_\_\_\_



## Patient Medical History Form - For Clinic Use ONLY

**PLEASE COMPLETE FORM LEGIBLY**

<b>Patient Name (Last, First, Middle):</b>		
<b>Previous Treatment Information:</b>		
Have you had Home Health for this injury?	Yes	No
If yes, when was your final day of treatment?		
Name of your home health provider:		Phone number:
Have you had any other treatment for this condition?	Yes	No
What kind of treatment did you have?		
<b>Surgeries and/or Hospitalizations</b>		
1.		Date:
2.		Date:
3.		Date:
4.		Date:
5.		Date:
<b>Medications (IF YOU HAVE A CURRENT LIST ALREADY MADE WE WILL GLADLY MAKE A COPY)</b>		
	Freq.	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
<b>Health Related Habits</b>		
Do you smoke?	Yes	No
If yes, packs per day?		
Number of years smoked?		
<b>SWIMMING SKILLS ARE NOT NECESSARY TO PARTICIPATE IN AQUATIC THERAPY</b>		
Do you know how to swim?	Yes	No
I will advise my therapist if there is any change in my physical condition or medications which may alter my response to any of the questions on this form and/or my ability to participate in physical therapy.		
Patient/Guardian Signature: _____		Date: _____



## Policy Acknowledgement and Signature Page

---

### Acknowledgment of the HIPAA Privacy Notice

By signing below I acknowledge that I was offered the opportunity to review the NCEPT Privacy Notice.

- I would like to have a copy of the office's HIPAA Privacy Notice.  
 I would not like to have a copy of the office's HIPAA Privacy Notice.  
 I refuse to sign because \_\_\_\_\_

---

### Acknowledgement of Broken Appointment Policy

By signing below I acknowledge that I have read and understand the Broken Appointment Policy.

**\*\*Failure to give 24 hour cancellation notice will result in a \$50.00 Broken Appointment Fee\*\***

---

### Acknowledgement of Financial Policy

By signing below, I acknowledge that I have read and understand the Financial Policy. Benefits quoted or provided to NCEPT by my insurance does not guarantee payable benefits and will be determined upon claim review. I understand that I am financially responsible for all charges whether or not covered by my insurance. Payments for office visit co-pays, deductibles, coinsurance, and non covered services are due at the time of service. If there is a balance after insurance, we will send you a statement. Statement balances are due 30 days from the date of the statement. Unpaid balances after the first billing cycle will accrue interest at the rate of 18% per annum.

---

### Authorization to Provide Medical Treatment and Assignment of Insurance Benefits

By signing below, I hereby authorize NCEPT Physical Therapy to provide medical treatment, to release my medical records to my insurance if necessary to process a claim, and allow assignment of benefits to NCEPT where a claim has been filed. I certify that all demographic information, insurance information, and health information is correct to the best of my knowledge. I will notify the NCEPT front office immediately if any of this information changes.

PRINT Patient/Guardian Name: \_\_\_\_\_

Patient/Guardian SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Relationship to Patient: \_\_\_\_\_

### **Media Consent:**

We would love to share your success! NCEPT has my permission to share my photo and/or written testimonial, name (first and last) with physicians, on NCEPT's webpage and/or social media pages, and on promotional items.

Agree  Disagree

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## To Our Patients Regarding Broken Appointments

We take broken appointments seriously at NCEPT, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment and showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require **24 hours** notice if you are unable to come to your appointment. When calling in, please have an alternative appointment date and time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a **\$50 charge** for a broken appointment without proper notice or no notice at all. This charge will not be covered by insurance so it will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your case manager and primary physician which could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses before it is finally erased. Please note: if you're in pain, come in and get it treated and if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem.

When you don't show as scheduled, three people are affected: You because you don't get the treatment you need as prescribed by the doctor and/or therapist, the therapist who now has a space in their schedule since the time was reserved for you personally, and another patient who could have been scheduled for treatment if you had given proper notice.

We appreciate your cooperation and thank you in advance for understanding of this matter. We look forward to working with you!



## Financial Policy

NCEPT believes that communicating our financial policy is good healthcare practice. We take great pride in treating and providing our patients with quality care and customer service. We understand that most, if not all of our patient's have health insurance. As a courtesy, we will happily file your insurance claim for you. Please understand your coverage and benefits are a contract between you and your insurance. Any and all information we obtain from your insurance does not guarantee payable benefits. As your provider, we offer and expect the following:

- You must contact your insurance carrier regarding your outpatient physical therapy benefits.
- We will file claims to your insurance(s) as a courtesy to you.
- Please note that secondary coverage does not and may not mean your services are covered at 100%.
- In acceptance of your insurance, your **office visit co-pays, deductibles and co-insurance are due at the time of service**. We cannot waive such payments as these are contracted requirements by your insurance.
- Please be aware that some- and perhaps all- of the services you receive may be non covered or deemed not medically necessary by Medicare or other insurers. This includes services your doctor and/or therapist believe are reasonable and necessary for your recovery. You may be asked to pay for these services in full at the time of the visit.
- Your payments are only estimates until your claim has been finalized by your insurance. If there is a balance after insurance, we will send you a statement. Statement balances are due 30 days from the date of the statement. Unpaid balances after the first billing cycle will accrue interest at the rate of 18% per annum. If all of your claims have been processed and there is a credit remaining on your account we will promptly reimburse you.
- We accept cash, check, major credit cards (except AMEX), and Care Credit.
- Financing is available exclusively through Care Credit. Financial arrangements must be prearranged and approved prior to appointments. Please let the front desk know if you would like more information on Care Credit.
- Unpaid balances over 90 days will be forwarded to a collection agency with additional costs to you.
- Worker's Compensation cases will require pre-authorization and primary insurance coverage in the event of denial for billing purposes.
- We do not bill third parties if you are here due to an auto injury. We can bill your auto insurance if you have MedPay available or your health insurance. Please note that your health insurance may not cover care due to auto injuries and may assign another party as liable.



# NOTICE OF PRIVACY 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.

## **NCEPT's LEGAL DUTY**

NCEPT is required by law to protect the privacy of your personal health information (PHI), provide this notice about our privacy practices, and follow the privacy practices that are described herein.

## **USES AND DISCLOSURES OF HEALTH INFORMATION**

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

NCEPT may also use or disclose your PHI 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, NCEPT's policy is to obtain your written authorization before disclosing your PHI. 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.

NCEPT may change its policy at any time. When changes are made, a new Notice of Privacy 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 Privacy Practices at any time.

## **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your PHI 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 PHI for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your PHI for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. NCEPT will consider all such 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 NCEPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our front office 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 NCEPT's health information practices or if you have a complaint, please contact the following person:

Kelsi Green

457 N Elm Street

Escondido, CA 92025

P: 760-489-1969 Email: [kgreen@ncept.com](mailto:kgreen@ncept.com)



## **Health Insurance Portability and Accountability Act of 1996**

The **HIPAA Privacy Rule** provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The **Security Rule** specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

### **Your Health Information is Protected by Federal Law**

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal Law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal Law that requires security for health information in electronic form.

### **The Privacy Rule**

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

### **HIPAA Security Rule**

A major goal of the Security rule is to protect the privacy of individuals' health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care. Given that the health care marketplace is diverse, the Security Rule is designed to be flexible and scalable so a covered entity can implement policies, procedures, and technologies that are appropriate for the entity's particular size, organizational structure, and risks to consumers' e-PHI.

### **How to File a Complaint**

If you believe that a covered entity or business associate violated your (or someone else's) health information privacy rights or committed another violation of the Privacy, Security or Breach Notification Rules, you may file a complaint with Office for Civil Rights. OCR can investigate complaints against covered entities and their business associates.