CORE Care 4070 West Street, Cambria, CA 93428 (805) 927-1055

WELCOME TO CORE CARE

Our Physical Therapists are California licensed and have considerable post-graduate education in Orthopedic and Sports Rehabilitation.

ATTENDANCE POLICY AND AGREEMENT

We strive to provide our patients with the utmost professionalism and excellence in service. Our commitment to your wellbeing and progress is something everyone in our clinic takes quite seriously. Your adherence to recommended visits, treatments and exercises is a vital component of your progress. Therefore, we request certain rules be followed to ensure optimum results.

When we schedule an appointment for you, we have reserved that time for you. We ask that if you need to change or cancel an appointment, that you give our office 24 hours' notice. Where 24 hours' notice is not given, a $25 rescheduling/no show fee may be charged and will be payable before the next appointment.

FINANCIAL POLICIES

We will bill most insurance companies as a courtesy to our patients. We ask that deductibles and co-payments be paid at the time of service. We will call your insurance company for specific benefit information and inform you of such by your second visit. If you need special arrangements, please ask to speak with our Office Manager. For balances that remain unpaid after 60 days, interest at a rate of 1.5% per month will be added.

There are many different insurance company policies and physical therapy benefits vary. We encourage you to become familiar with your benefits. We will call your insurance company for benefits; however, we will not guarantee that they will pay the exact amount stated. All unpaid charges by the insurance company will be the responsibility of the patient or guardian.

MEDICARE PATIENTS

You are required to see your physician every 90 days.

ATTENTION WORK COMP PATIENTS

If you have two instances (in any combination) of a cancellation (without 24-hour notice) or no-show in a 30-day period, your future reserved appointments will be cancelled. You will then only be able to make same-day appointments. A notice will also be sent to your doctor and/or case manager. If you cancel or no-show to a same day appointment, you will be discharged from treatment due to non-compliance and your doctor and/or case manager will be notified.

ATTENTION PRIVATE INSURANCE PATIENTS

If you have three instances (in any combination) of a cancellation (without 24 hours' notice) or no-show in a 30-day period, your future reserved appointments will be cancelled. You will then only be able to make same-day appointments. You will be discharged from treatment (due to non-compliance) if you cancel or no-show to a same-day appointment.

We greatly appreciate you as a patient and strive to accomplish wonderful results and success for you.

By signing below, you certify that you have read and understand the above policy.

_____ _____

Patient/Guardian Signature Date

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SUMMARY OR NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices.
The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that notice for further information.

USES AND DISCLOSURE OR HEALTH INFORMATION

We will use and disclose your health information to treat you or to assist other health providers in treating you. We will also use and disclose your health information to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your Witten consent.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION

In the following circumstances, we may disclose your health information without your written authorization.

- To family members and close friends who are involved in your healthcare
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purpose of their audits, investigations, and other oversight activities.
- To Government authorities to prevent child abuse or domestic violence.
- To the FDA to report product deficits or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

PATEINT RIGHTS

As our patient, you have the following rights:

- To have access to and/or copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OR RECIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood this notice.

Patient Name:	Date:
Patient/Guardian Signature:	

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CONSENT TO TREATMENT AND THERAPEUTIC PROCEDURES

I_____ hereby consent to the therapeutic procedures outlined below, to be performed by CORE Care and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization, clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice electric stimulation and ultrasound; and special procedures such as taping, neuromuscular electronic stimulation and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Core Care or from any other source.

Patient Signature:	Date:
Physical Therapist Signature:	Date:

FINANCIAL RESPONSIBILITY POLICY

I understand that CORE Care is billing my insurance as a courtesy, and I hereby assign all physical therapy benefits directly to CORE Care. I understand that most insurance companies, (including Medicare), pay only a certain percentage of patient services depending on the policy, and should they deny my claim or any portion due, I am financially responsible and agree to pay for all charges related to services provided to me at CORE Care, regardless of the status of my insurance claim.

I agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owed on my account, I will pay CORE Care promptly upon receipt of the statement. I understand that interest at a rate of 1.5% per month may be added to unpaid balances due for coinsurance, co-payment, or deductible.

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to CORE Care for any services furnished to me by CORE Care.

I understand my signature authorizes the release of my medical information to the insurance company, indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims. This information will only be discussed to the insurance company once it has been requested and deemed necessary information needed to determine these benefits payable to related services by the insurance company.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. This authorization will remain valid until rescinded in writing.

I have read the above and fully understand the terms thereof.

This is a teaching facility, you may be treated by a physical therapy intern, under the supervision of a licensed physical therapist.

Patient Signature:	Date:

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PATIENT INFORMATION

Patient Name:		
Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
SSN:	Birthdate:	Age:
Email:		
Employer:	Occupation:	Family Dr.
Is problem due to an auto or workplace accident?		
Person responsible for charges (if other than yourself)		
Relation:	SSN:	
Address:		
City:	State:	Zip:
Birthdate:	Employer:	
Home #:	Cell #:	Work #:

INSURANCE INFORMATION

Policy Holder (if other than yourself)		Birthdate:
Address:		
City:	State:	Zip:
Phone #:	SSN:	Employer:

EMERGENCY CONTACTS

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

HOW DID YOU HEAR ABOUT US?_____

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MEDICAL HISTORY INTAKE FORM

Patient Name:	Date:
Birthdate:	Age:
What is the reason for your visit today?	
If you are female, are you pregnant or trying to become pregnant?	

HAVE YOU EVER BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?

Cancer	Yes	No	Osteoporosis	Yes	No	Hypoglycemia	Yes	No
High Blood Pressure	Yes	No	Heart Disease	Yes	No	Angina or Chest Pain	Yes	No
Shortness of Breath	Yes	No	Stroke	Yes	No	Kidney Disease/Stones	Yes	No
Urinary Tract Infection	Yes	No	Allergies	Yes	No	Asthma	Yes	No
Rheumatic/Scarlet Fever	Yes	No	Hepatitis/Jaundice	Yes	No	Cirrhosis/Liver Disease	Yes	No
Polio	Yes	No	Chronic Bronchitis	Yes	No	Pneumonia	Yes	No
Emphysema	Yes	No	Migraines	Yes	No	Anemia	Yes	No
Ulcers/ Stomach Problems	Yes	No	Depression	Yes	No	Back/Neck Injuries	Yes	No
Arthritis/Gout	Yes	No	Hemophilia	Yes	No	Thyroid Problems	Yes	No
Tuberculosis	Yes	No	Fibromyalgia	Yes	No	Epilepsy	Yes	No

If you answered yes to any of the above, please explain:
Please list any medications you are taking (prescription or over the counter):
Do you have Diabetes? Type:
How is it controlled?
Do you smoke or chew tobacco?
Do you take steroids or anticoagulant medication?
Have you had and illnesses within the last 3 weeks?
Have you had any past surgeries?
Do you have a (circle all that apply): Pacemaker Transplanted Organ Joint Replacement Metal Implants
Have you had any tests for this problem? X-Ray MRI CT Lab
Where?

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MEDICARE QUESTIONNARE

Please Note: Medicare requires This information

Patient Name:	Date:
Height:	Weight:

Have you fallen two (2) or more times in the past year?	Yes	No
Please explain:		
Have you been injured by a fall In the past year?	Yes	No
Please Explain:		

MEDICATION LIST

Name (Prescriptions, Over the counter drugs, vitamins, and herbal supplements)	Dosage (mg, cc, etc.)	Method (oral, injection, etc.)	Frequency (daily, weekly, monthly)

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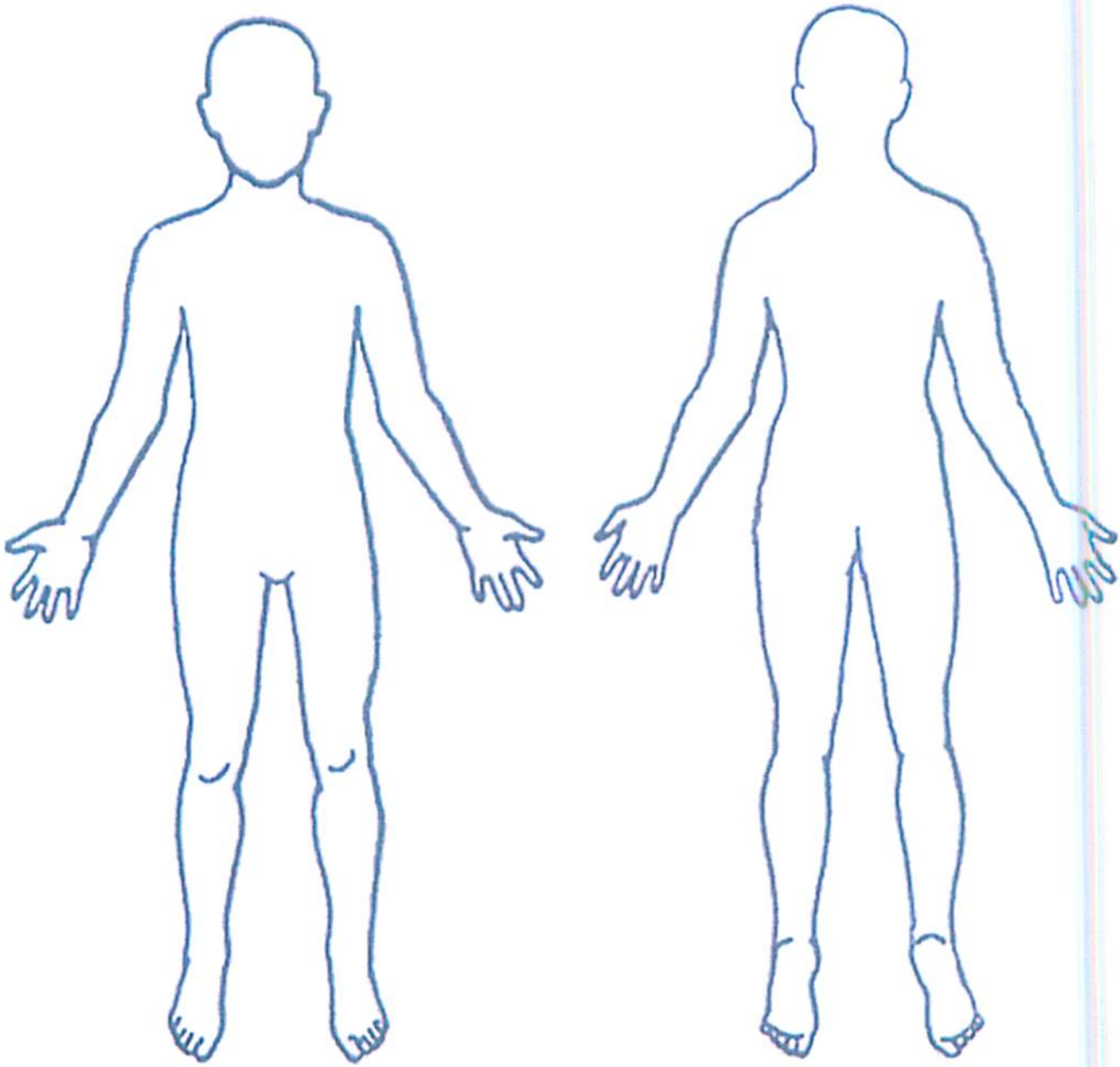
Patient Name:	Date:

PLEASE MARK THE AREAS WHERE YOU FEEL PAIN ON THE BODY DIAGRAM BELOW.



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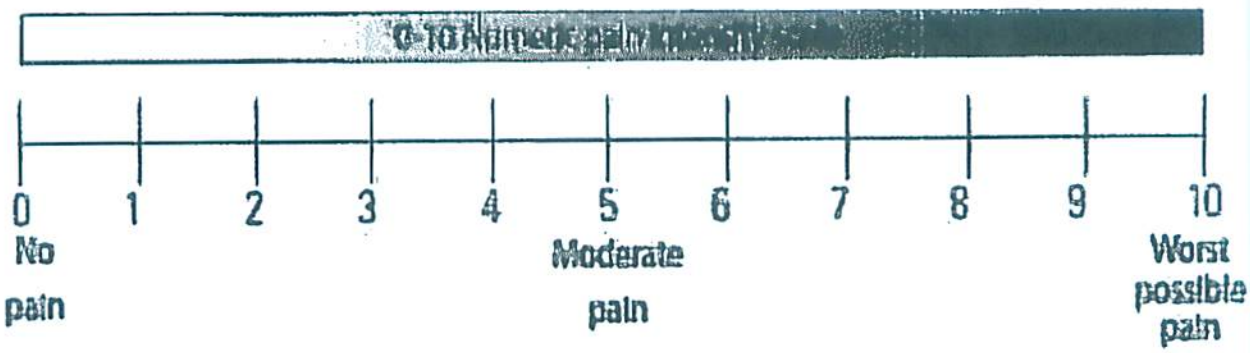
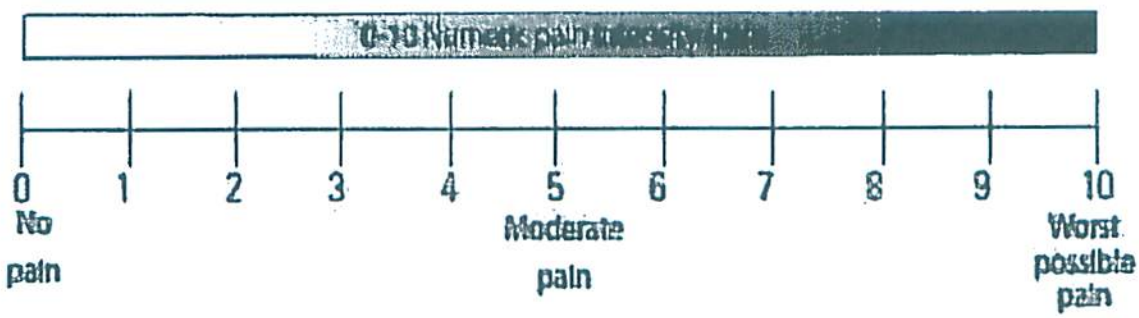
DESCRIBE HOW YOUR DAILY ACTIVITIES ARE AFFECTED BY YOUR PAIN

(LIST SPECIFIC ACTIVITIES AT WORK OR HOME THAT YOU ARE NOT ABLE TO PERFORM WITHOUT PAIN)

Please mark your pain level while **AT REST** on the scale below



Please mark your pain level **DURING ACTIVITY** on the scale below



Name:	Date:

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Authorization: This authorization for use of disclosure of my health information is required by state and federal law.

I hereby authorize CORE Care to release my health information to the following listed office and/or person.

Name: (List self if records are being released to patient)		Phone:
Address:		Fax:
City:	State:	Zip:

This authorization applies to the following information:

- Any part of my medical records.
- Any part of my medical records during the date frame of: _____
- The following records or types of information (include dates of treatment)

  _____

Purpose or need for the information requested (circle one):

Continued Care Insurance Legal Transfer Personal

Expiration: This authorization expires (enter date_):

Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless this disclosure is required or permitted by law. This protection does not extend to recipients outside of the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: 4070 West Street, Cambria, CA 93428
- My revocation will be effective upon receipt, but will have no impact on uses of disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization.
  If this box is checked, copy was requested and received. Initials_____

Patient Name: (please print)
Patient/Personal Representative Signature:
Witness:
Records sent on the following date:

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Completed by:	Date:

DIRECT PYSICAL THERAPY TREATMENT SERVICES DISCLOSURE

You are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Your physical therapist is a professional employee, partner, or owner in this practice, which will bill your insurance company and/or the patient for professional physical therapy services recommended and administered by the PT in the best interest of your personal health.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first. After which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California., or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine acting within his or her scope of practice, a dated signature on the physical therapists plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

Patient/Guardian Signature:	Date:

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE