DASH Therapy

Initial Evaluation – Pre-Exam Questionnaire

CONFIDENTIAL

In order to evaluate your condition fully, please be as accurate as possible.

Name: **Last** _____ **First** _____ **M.I** _____

Address: _____ **City:** _____

Date of Birth: _____ **Age:** _____ **Home Phone#:** _____

Gender: Female Male **Cell Phone#:** _____

Social Security# : _____

Marital Status: **M S W D** **Other:** _____ **E-mail Address:** _____

Ocupation: _____ **All appt. reminders will be sent via email**

Employer: _____

Address: _____ **Phone#:** _____

Emergency Contact: **Name:** _____ **Phone#:** _____ **Relationship** _____

Referring Doctor : _____ **Primary Doctor:** _____

Primary Complaint: _____

INSURANCE INFORMATION

Is this a Workers Compensation Claim: YES NO

Are you working now? YES NO **If Not, Date last worked?** _____

Workers Comp Insurance: _____ **Phone:** _____

Adjuster Name: _____ **Phone#:** _____ **Fax#:** _____

Case Manager: _____ **Phone#:** _____ **Fax#:** _____

Date of Injury: _____ **Date of Surgery:** _____

OTHER INSURANCE

Insurance Name: _____ **Phone:** _____

Name of Primary Subscriber : _____ **DOB:** _____

Subscriber ID# _____ **Group#** _____

MEDICARE PATIENTS ONLY

Have you been in a skilled nursing facility within the last 30 days? YES NO

Name of Facility: _____ **Phone:**

UPDATED INFORMATION

Change of Address: _____ **Phone:** _____

_____

Employer: _____

Other Insurance Company

Insurance Name: _____ **Phone:**

Name of Primary Subscriber : _____ **DOB:**

Subscriber ID# _____ **Group#** _____

Summary Notice of Privacy Practices

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

The law requires that we maintain the privacy of your medical information. You must be given a copy of this notice. We must abide by the terms of this notice. If the notice is revised, a copy will be available upon request.

We use and disclose your medical information for **Treatment**. For example, we will call your doctor to discuss the progress that you have made as a result of your therapy treatments. We will use and disclose your medical information for **Payment**. For example, we may provide your insurance plan with information about your diagnosis and treatment. We will use and disclose your medical information for **Health Care Operations**. For example, we may use your medical information to evaluate and/or improve our services. We may contact you by phone or mail to remind you of an appointment, to discuss other health care matters or to discuss payment for our services.

We may use and disclose your medical information to notify you of treatment alternatives or other health related benefits and services. We may disclose your medical information to those individuals who are involved in your care or payment for that care. You must notify our office in writing if you do not want us to make these communications.

We may use your medical information as required or permitted by law. Any other uses and disclosures will be made only upon your written authorization. You can revoke and authorization at any time by notifying our office in writing.

You have the following rights: **to receive a copy of your privacy notice; to request restrictions on the used and disclosures of your medical information and to receive confidential communications; to inspect and copy your medical information; to request an amendment to your medical information; and to an accounting of disclosures of your medical information.**

Contact Information: If you believe that your privacy rights have been violated, please contact our Designee at (559) 627-3274 or the U.S. Secretary of Health and Human Services.

I hereby acknowledge my receipt and understanding of the ***NOTICE OF PRIVACY PRACTICES*** .

IMPORTANT NOTICE

I agree to pay $25.00 fee if I NO SHOW or CANCEL an appointment with less than a 24-hour notice. _____

Initials

All services rendered are charged directly to patients. Patients are financially responsible for payments unless other arrangement have been made. Payment is due at time of service. I hereby authorize DASH THERAPY treatment and release of billing information necessary to process my claims for payment, and be payable to them. In no way whatsoever will I revoke the assignment / authorization without first obtaining written consent from DASH THERAPY this assignment / authorization shall be as valid as my insurance form. A photocopy of this assignment shall be as valid as the original.

Patient Signature: _____ **Date:** _____

Responsible Party (If Minor) : _____ **Date:** _____