Paragon Physical Therapy and Rehab

2585 Miracle Mile, Ste 107
Bullhead City, AZ 86442
Office (928) 444-8168
Fax (928) 444-8169

(Please Print and Sign Clearly) Please bring your referral, ID, and Ins. Cards

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Social Security#: _____ **Birth Date:** _____ **Sex:** **Male** ☐ **Female** ☐

Marital Status: (circle one) Single Married Widowed Divorced Separated

Employer: _____ **Occupation:** _____ **Phone #:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Refering Physician: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Primary Insurance Company: _____

Phone: _____ **ID/Policy #:** _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's Birth Date:** _____

Home Phone: _____ **Cell Phone:** _____ **Relation to Patient:** _____

Secondary Insurance Company: _____

Phone: _____ **ID/Policy #:** _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's Birth Date:** _____

Home Phone: _____ **Cell Phone:** _____ **Relation to Patient:** _____

Is this illness/injury due to a **Work** related accident/condition? ☐ Yes ☐ No
If yes, please complete information below.

Workman's Comp. Insurance Company: _____

Employer: _____ **Claim #:** _____ **Date of Injury:** _____

Claims Adjuster: _____ **Phone:** _____

Is an insurance provider other than your primary insurance to be billed for services? ☐ Yes ☐ No
If yes, please complete information below.

Other Insurance Provider to be billed: _____

Is this a Lien? ☐ Yes ☐ No **If yes, Attorney's Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Claim#:** _____ **Date of Injury:** _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: (Please Read and Sign)

I hereby authorize payment of medical benefits to Paragon Physical Therapy and Rehab for services rendered to my Dependent or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I hereby give my consent to treatment to an authorized PT/PTA of Paragon Physical Therapy and Rehab.

Patient or Legal Guardian Name (Please Print): _____ **Date:** _____

Authorized Signature: _____ **Date:** _____

PARAGON
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Patient Health History

Name:_____ **Date:**_____

Reason for your visit:_____

Past Medical History: (Please circle each condition that you have)

AIDS/HIV	Diabetes	Chronic Bronchitis	Pulmonary Fibrosis
Asthma	Emphysema	Neurological Disorder	Rheumatoid Arthritis
Bronchiectasis	Fibromyalgia	Osteoarthritis	Scoliosis
Cancer	Heart Disease	Osteoporosis	Spine Issues
CVA/Stroke	Lung Disease	Pacemaker	High Blood Pressure
Cystic Fibrosis	Kidney Disease	Parkinson's Disease	

Other:_____

Hearing Loss: Left Right Both Hearing Aids

Vision Problems: Glaucoma Macular Degeneration Cataract

Medication: _____

_____

_____

Do you take blood thinners? Yes/No

☐ **No Known Allergies** ☐ **Known Allergies and Reactions: (Please List)** _____

Past Surgical History/Procedures related to current symptoms:_____

_____

_____

_____

Have you had Physical Therapy or Pulmonary Therapy in the past year? YES/NO

If Yes, Where?_____

Source of Information: ☐ **Patient** ☐ **Family** ☐ **Other:**_____

Therapist Signature:_____ **Date:**_____

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501e Patient Rights

All patients have a right to equitable and humane treatment at all times and under all circumstances. All caregivers are obligated to recognize and respect a patient's individuality and dignity, and to create and foster relationships based on mutual acceptance and trust. No person should be denied impartial access to treatment or accommodations which are available and medically indicated on the basis of race color, creed, national origin or the method of payment selected for care.

Every patient in a healthcare facility retains a right to privacy, which should be protected by the staff, regardless of the patient's economic status or the source of payment chosen for his or her care. Representatives of agencies unrelated to the facility, and who are not involved in the patient's care, should be restricted from interviewing, interrogating or observing patients or otherwise interfering with a patient's care. The facility should be a patient's sanctuary where healing may take place.

Caregivers should respect the privacy of a patient's body to the greatest extent possible. Examination and treatment areas should be designed to protect a patient's privacy by shielding him or her from the view of others.

A patient's history should be confidential. A private setting should be available in which a patient may disclose in confidence his or her history to a staff member.

A patient has the right to communicate with those responsible for his or her care, and to receive from them adequate information regarding the nature and extent of his or her medical problem, the planned course of treatment and the prognosis. Patients also have a right to be instructed in self-care. When language barriers arise, an interpreter should be provided. Cultural variations in language, as well, may impede understanding. A staff member or other trained individual should be available to facilitate communication between staff and patients.

A patient also has the right to complete confidentiality of his or her records and files unless previously signed and dated authorization and release forms are completed.

The patient or patient's family members can address any concerns related to "Patients' Rights" to the facility Administrator.

Patient Signature_____ **Date**_____

PARAGON
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And Rehab

Counseling/ Social Services Referral Form

We have a licensed clinical social worker that can help you with a variety emotional and social service needs. Please mark the item below that best describes your needs.

Denial of Services

☐ I do not need any of the services listed below

Counseling

☐ Individual Counseling *Description: For individuals who are experiencing some or all of the following symptoms: sadness, tearfulness, hopelessness, loss of interest in activates that previously brought you joy, thoughts of suicide, feeling overwhelmed by one's life or medical condition. Also symptoms of anxiety which can include easily frustrated, constant worry or exaggerated fears.*

☐ Support Group Referral: *Description: For individuals who are seeking support from others who are in similar situations, have similar interests or needs. Helps to know a person is not alone and can learn ways to cope with life's challenges.*

☐ Therapy Group Referral: *Description: Therapy groups are facilitated by a licensed therapist who guides a group of individuals with similar experiences or needs.*

Information and Referral

☐ Community Resources: *Description: Information and referral of a variety of state and county services that can assist with social service needs. This can include help with food, utilities, possible in home help services and assistance with prescription costs. Most of these programs are for individuals with low income.*

If any services are requested continue filling out information below.

Briefly describe your need for resources so the social worker can bring them to your appointment when you meet with them.

_____

_____

_____

_____

DOB:_____ Phone #:_____ Insurance Provider:_____

_____

Patient or Legal Guardian Name (Please Print):_____Date:_____

Authorized Signature:_____Date:_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

This Notice of Privacy Practices describes how Paragon Physical Therapy and Rehab may use and share your medical information with others to carry out Treatment, Payment of health car operation (TPO) and for other purposes that are permitted or required by law. IT also describes your rights to see your protected Health Information (PHI). Protected Health Information is information about you and services that you have received. This would include information such as your name, address, date of birth, diagnosis, treatment, or other information that may identify you and your past, present or future physical or mental health or treatment you receive.

Uses and Disclosures of Your Medical Information:
Your PHI may be used and shared by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of Paragon Physical Therapy and Rehab, and any other uses permitted or required by law.

Treatment:
We will use and share your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (e.g. sending PHI about you to a specialist as part of a referral).

Payment:
Your PHI will be used, as needed to receive payment for your healthcare services. For example, getting approval for a hospital stay may require that your PHI be shared with the health plan to obtain approval for the hospital admission. Or for example, sending billing information to your insurance company, Medicaid or Medicare.

Health Care Operations:
We may use or disclose, as needed, your PHI in order to support the business activities of Paragon Physical Therapy and Rehab. These activities, training of medical students, licensing, health oversight audits or inspections, marketing and fundraising activities, and conducting or arranging for other business activities. We may contact you to remind you of your appointments by phone or email.

We may use or disclose your PHI in several other situations without your authorization. We also disclose PHI when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to a valid judicial or administrative Order.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke your authorization at any time, in writing.

You have the right to inspect and request a copy of your PHI. Federal law, however, does create some exceptions to the right and exempts the following records: psychotherapy notes, information gathered to be used in a civil, criminal, or administrative action or proceeding.
You have the right to request a restriction of your PHI. This means you may ask us not to use pr share any part of your PHI for the purpose of Treatments, Payment of Healthcare Operations. You may also request that any part of your PHI not be disclosed to family members, friends, or other individuals who may be involved in your care. While Paragon Physical Therapy and Rehab will consider any reasonable request for restrictions, we are not required to agree to your request.
You have the right to request that PHI about you be communicated to you in a confidential manner, such as sending mail to an address other that your home or by other means.
You have the right to obtain a paper copy of this notice from us upon request at any time.
You have the right to request that HPFC amend your PHI. If we deny your request for an amendment you have the right to file a statement of disagreement with us and we may prepare an answer to your statement and will provide you with a copy of any such answer.
You have the right to receive an accounting of certain disclosures, of any, of your PHI.
You have the right to complain to HPFC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Paragon Physical Therapy and Rehab. You may file a complaint with us by notifying our HIPAA Privacy Office at the address or phone number below. Filling a complaint will not affect your health care services in any way.
In order to exercise any of the above rights, you may ask any staff member in the Paragon Physical Therapy and Rehab office for the proper forms and instructions.

We reserve the right to change the terms of this notice for all records and will inform you by posting the revised notice in the waiting area.

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices and follow the information practices that are described in this notice. If you have any questions or complaints, please contact our HPFC Privacy Officer at

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Authorized Signature:_____ **Date:**_____

FINANCIAL CONDITIONS OF TREATMENT

PATIENT RESPONSIBILITY: As a patient receiving medical care, it is my responsibility to be aware of my insurance coverage and limitations. Many insurance companies require pre-authorization for physical therapy treatments. It is my responsibility to determine insurance benefits and Paragon Physical Therapy and Rehab will assist me in obtaining the necessary pre-authorization when needed. Failure to obtain necessary pre-authorization may result in a reduction or rejection of benefits by the insurance company.

CONFIDENTIALITY & RELEASE OF INFORMATION: Confidential information expressly identifies the medical nature of the services rendered to a patient and includes all information and records obtained in the course of treatment. Paragon Physical Therapy and Rehab may disclose all or any part of the patient record to any person which is, or may be liable for, or responsible for payment of all or part the facilities charges including but not limited to, insurance companies, medical service companies, worker's compensation carriers, employers and welfare funds.

ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I request and authorize my insurance company to pay Paragon Physical Therapy and Rehab directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named below to release such information to the Social Security Administration, its intermediaries or carriers.

POLICY ON PATIENT ACCOUNTS

PRIMARY INSURANCE: We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payments directly to Paragon Physical Therapy and Rehab and you will be responsible for any deductible, co-payments or other patient balances. Medicare regulations mandate that all providers must attempt to collect the co-pay or provide evidence of the patient's inability to pay. If you have special financial needs, please feel free to discuss with our Office Manager in order to establish an extension for credit terms.

SECONDARY/SUPPLEMENTAL INSURANCE: We bill a majority of secondary and supplemental insurance companies. Please check with the Office Manager if you wish for your secondary/supplemental insurance to automatically be billed.

PATIENT RESPONSIBILITY: If you have a balance on your account you will receive a monthly statement until the account is paid in full. Payment options include cash, check, Visa and Mastercard.

PARAGON HEALTHCARE SERVICES: Paragon Physical Therapy and Rehab will bill your primary and secondary insurance one time. We will make one follow up and call and/or letter in an attempt to collect payment. If payment is still not received you will be held responsible for the remainder of the account.

PAST DUE ACCOUNTS: Delinquent accounts will be assigned to an outside agency for collection and reviewed by the Office Manager for further action. All accounts past due more than 90 days will accrue interest at 1% monthly.

PAYMENTS MADE TO PATIENT: Some insurance companies choose to make payments directly to the patient (i.e. Blue Cross/Blue Shield). These payments with attached explanation of benefits must be surrendered to Paragon Physical Therapy and Rehab when received by the patient or the patient will be held responsible for 100% of fees charged.

I have read and understand this financial agreement. I have had the opportunity to ask questions and accept the responsibility of its terms.

Patient or Legal Guardian Name (Please Print)_____ Date_____

Authorized Signature_____ Date_____