JACOBO

Physical Therapy & Complete Wellness
Gracie Jacobo, RPT

WARM WELCOMING

Welcome. Thank you for choosing us to care for your Physical Therapy and rehabilitation needs. It is an important part of a positive therapy and rehabilitation experience, making you feel at ease from the moment you walk in our door. Our staff is friendly and highly trained, and for your comfort our reception area is warm and inviting.

To allow your scheduling convenience, our office is open from Monday-Friday, 8:00am to 6:00pm. No one should have to wait any longer than absolutely necessary for physical therapy and rehabilitation care. We are also available to see emergencies any day with a minimum of waiting.

We are always happy to answer any questions you may have. Following an examination, we will work with each patient to determine what is best for them. Everyone is given treatment recommendations in writing.

For your convenience, we take care of the insurance paperwork for you. We will explain all you insurance benefits, pre-authorize your treatment and complete all forms. Our staff are familiar with all types of insurance and will help maximize your benefits. It is important, on your first visit, that you bring insurance claim forms (completed) and your benefit book.

Giving you professional, comfortable service is our number one priority. The latest techniques, procedures and modalities are used by our staff. Our office is equipped with the best of the most modern equipment and our skilled staff has been carefully selected to meet your needs.

Sincerely,
Jacobo Physical Therapy, Inc.
1820 Chester Ave
Bakersfield, CA 93301
Phone: 661-631-8793
Fax: 661-631-9257

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Physical Therapy & Complete Wellness

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 13, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice affective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practice, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations, for example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide for you.
Healthcare Operations: We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.
Your authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use our health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. You revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a writing authorization, we cannot use or disclose our health information for any reason except those described in this Notice.
To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with our healthcare or with payment for you healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of our health information, we will provide you with an opportunity to object to such uses of disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based as a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required By Law: we may use or disclose your health information when we are required to do so by law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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Physical Therapy & Complete Wellness
Gracie Jacobo, RPT
You May Refuse to sign This Acknowledgement

I,__________________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name:

____ Date________________.

Signature

I also Authorize Jacobo Physical Therapy to give any information within regards to my medical condition as well as medical records to my spouse or family member named below.

_______YES _______NO

____

Name of Authorized Spouse of Family Member

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other(Please Specify)

____

____

PATIENT INFORMATION/INFORMACION DEL PACIENTE

- Name/Nombre:____ Date/Fecha: ____________.

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PLEASE FILL OUT ENTIRE SECTION

- Address/Direccion:________________________________Phone/Telefono:__________________.
- City/Ciudad:_________________________State/Estado__________ Zip/Codigo:____________.
- E-mail: ____.
- Date of Birth/Fecha de Nacimiento:__________________.
- (__Single/Soltero) (__Married/Casado)
- Date of Consent-injury-surgery/Fecha de trauma o cirugia:_______________________________.
- SS#/Seguro Social:_______________________Ref Doctor/Medico:_________________________.
- Employer/Dueno:________________________________Phone/Telefono:____________________.
- Employer's Address/Direccion del Empleador:____.
- Reason for Physical Therapy/Motivo de su Visita:_____________________________________.
- Have you had previous physical therapy for your present condition/ Ha tenido terapia fisica anteriormente con el problema que hoy tiene?

  ____.
- Do you have or have you had any of the following/Ha tenido o tiene lo siguiente:

PLEASE FILL OUT ENTIRE SECTION

- Diabetes/Diabetis Y N
- High Blood pressure/Alta Pression Y N
- Heart Attack/Ataque del Corazon Y N
- Pacemaker/Marcapasos Y N
- Headaches/Dolores de Cabeza Y N
- Kidney Problems/Problemas en los Rinones Y N
- Nervous Disorders/Nervios Y N
- Sensitive Heat/Ice/Sensibilidad al Hielo/Calor Y N
- Pregnant/Embarazo Y N
- Allergies/Alergias Y N
- Hernia(Vent/Inguin)Inguinal Y N
- Seizures/Ataques de Epilepsia Y N
- Metal Implant/Metal Implantado Y N
- Cancer Y N

If yes, to any above please explain/ Si contest si a la preguntas por favor explique:

____

____

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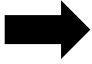
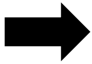
EMERGENCY CONTACT

Please provide us with two emergency contact numbers:



1- **NAME**:_______________________________**RELATIONSHIP**____________________
PHONE NUMBER:__________________________.



2- **NAME**:_______________________________**RELATIONSHIP:**____________________
PHONE NUMBER:__________________________.

Please provide us with an alternate address:

1- ____.

We will only use the number/address if we are unable to reach you at the number/address you provided on the patient information page. Thank you for your cooperation.

CONSENT FOR TREATMENT

RELEASE OF INFORMATION- INSURANCE ASSIGNEMT-FINANCIAL AGREEMENT

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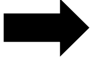


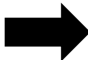
Patient OR Minor:____.

1. **CONSENT FOR TREATMENT**: I hereby agree to the performance of such examination and procedures as in the opinion of the attending physical therapist, or any contractors, is deemed necessary on the patient name above. If the patient is a minor, I certify that I am either the parent of the legal guardian.

2. **RELEASE OF INFORMATION**: To the extend necessary or determine liability for payment and to obtain reimbursement, the physical therapist may disclose portions of the patient's charge, include but not limited to insurance companies, health care services plans of workers compensation carriers. I hereby state and agree that photocopy and or telecopy of will be valid and binding on all parties involved as the original copy.

3. **INSURANCE AGREEMENT**: I do hereby assign irrevocably direct payments to the physical therapist, and any other contractors, thee health care benefits, due for the total charge or payment equal to the reimbursement rate, as may be appropriate, for any services rendered. I understand that I am financially responsible to the physical to the physical therapist for charges not covered by this assignment. I hereby instruct and direct any obligated company or individual to pay by check made out and mailed directly to the note provider.

4. **FINANCIAL AGREEMENT**: The undersigned agrees, whether he/she as agent or as patient. That inconsideration of the services to be rendered to the patient, he/she individually obligates him/ her to pay the account of the health professionals in accordance with the regular rates and terms of the health professionals. I understand that Jacobo Physical Therapy shall have the right to any time refuse to admit me or to provide health care or treatment for me. The health professionals, as a courtesy to the patient, agree to extend credit by awaiting payment from the insurance company, provided any deductible and co-payments are paid in full within thirty days of receiving the bill. If the patient should discontinue treatment against the recommendations of the physical therapist, then the entire balance is due and payable immediately. Should the account be referred to nay attorney for collection or to a collection agency, the undersigned shall pay actual attorney's fees and collection expenses, all delinquent account shall be charged a fifteen (15%) percent billing charge per month or at the legal rate. To avoid a missed appointment fee, we require a 24 hour cancellation notice prior to the appointment (office policy is to charge approximately one third of the average visit fee). There will be a twenty-five ($25.00) dollar charge for returned checks. I agree that Jacobo Physical Therapy be given Irrevocable Power of Attorney to endorse/ sign my name on any checks for payment of my health professional's bill. The health professionals and their staff are acting as an agent in filling for insurance benefits assign to them; however, the health professional can assume no responsibility for guaranteeing covered charges as billed.



X____**Date:** ____________________.
Patient's signature or Parent or Legal guardian of minor child

Appointment Cancellation/No Show Policy

Jacobo Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Therefore, we provide reserved time slots for each

patient in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

Please read the following policy to better help us, help you.

1. We require that you cancel any appointment you cannot make with no less than 24 hours' notice. We will get you rescheduled at that time. If you know you cannot make your appointment and it is after our business hours, please note that you can still call as we roll our phones every night and will receive your message in the morning. Calling after hours and leaving a message the day before is better than calling the morning of your appointment. You may also send an email directly from our website at www.jacobopt.com.
2. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice. Repeated missed appointments will be reported back to the referring doctor and we will no longer be able to schedule you.
3. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
4. Please note, we may charge a $25 missed appointment fee for no-shows and cancellations with less than 24 hours' notice. This amount is your responsibility as insurance will not cover a missed visit fee. To avoid the $25 fee, call the office to reschedule any appointments you cannot attend 24 hours in advance.

We understand that there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office in order to adjust your time as soon as possible.

I have read and understand the cancellation/no show policy.

Patient Signature: ____ Date: ________________

Physical –Patient 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 California law, and not by a lawsuit or resort to court process except as California law providers for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

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Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims arise out of the relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claim court against the physician's partners associates, association, corporation or partnership , and the employees, agents and estates of any of them , must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved arbitration.

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 of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate 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 or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be 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.

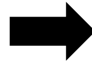
The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure sections 340.5 and 667.7 and Civil Code Section 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, deposition may be taken prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall 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 California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provision relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date signed (including, but not limited to, emergency treatment) patients should initial below:

Effective as of date of first medical services



______________________________.

Patient's or Patient Representative's Initials

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 understood that the right to receive a copy of the arbitration agreement. By my signature below, I acknowledge that I have received a copy.

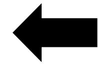
NOTICE: BY SIGNING THIS CONTRATCT YOU ARE AGREEMENT TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:______________________________ ______________

Physician's or Authorization Representative's Signature (Date)

By:______________________________ ____________.

Patient's or Patient Representative's Signature (Date)



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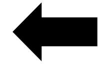
Print or Stamp Name of Physician, Medical Group, Or Associate Name

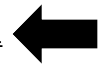
By:______________________________.

Print Patient's Name



______________________________.

(If Representative, Print Name and Relationship to Patient)



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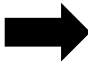
Physical Therapy & Complete Wellness

Gracie Jacob, PT

1820 CHESTER AVE, BAKERSFIELD, CA 93301

Phone: 661-631-8793 | Fax: 661-631-9257

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION



Patient's Name: ____ Date of Birth: ____/____/________

I request and authorize [Authorized Individual] to release healthcare information of the patient named above to:

JACOBO PHYSICAL THERAPY

1820 CHESTER AVE

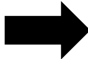
BAKERSFIELD, CA 93301

This request and authorization applies to:

- ○ Healthcare information relating to the following treatment, condition, or date
- ○ All healthcare information
- ○ Other

ADDITIONAL NOTES:

____



Patient Signature: ____ Date: __________________

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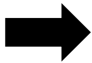
Physical Therapy & Complete Wellness
Gracie Jacob, PT

Appointment Reminder Consent

Complete this form and sign below to give your permission for Jacobo Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

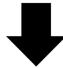


☐ Jacobo PT Clinic may send email messages to confirm my upcoming appointments.

☐ Jacobo PT Clinic may send cell phone text messages to confirm my upcoming appointments.

I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.



We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

☐ ALLTel

☐ AT&T

☐ Boost Mobile

☐ Cingular

☐ Cricket Wireless

☐ Metrocall

☐ MetroPCS

☐ Nextel

☐ Qwest

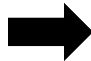
☐ Sprint PCS

☐ T Mobile

☐ US Cellular/Government Issued

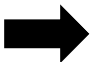
☐ Verizon

☐ Virgin Mobile



____

Signature of Patient or Guardian



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Date