



## OUTPATIENT REGISTRATION

Please Print

Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Single Married Widowed Separated Divorced

Patient Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MEDICAL HISTORY / SUBJECTIVE INFORMATION**  
Outpatient Services

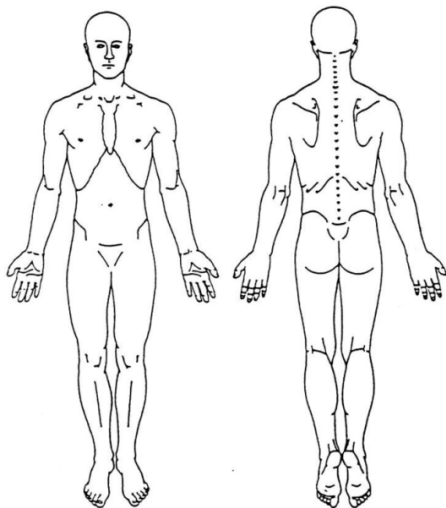
Your Name :				Today's Date:		
Date of Birth:	Age:	Height:	Weight:	Do you Smoke?	No	Yes
Sex: Male Female	If female, are you pregnant?	No	Yes (if yes, 1 <sup>st</sup> Trimester	2 <sup>nd</sup> Trimester	3 <sup>rd</sup> Trimester)	

**Have you ever been diagnosed with the following?**

Tuberculosis	No	Yes	Cancer	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes	Stroke	No	Yes
Heart Condition	No	Yes	Epilepsy	No	Yes	Respiratory Problems	No	Yes
Other: _____				No	Yes			

**Tell us about the condition you came in for today:**

- When did you first notice pain or have functional problems due to the condition/injury? (Specific Date) \_\_\_\_\_
- Have you experienced any recent flare ups? No Yes if yes, when? (Specific Date) \_\_\_\_\_
- What activities are limited due to this condition/injury? (i.e.: lift, reach) \_\_\_\_\_
- When and how did your injury/symptoms occur? Recreation Home Work Auto Accident Unknown Other
- Have you had a fall in the past 3 months? No Yes
- Do you feel that you lose balance often? No Yes
- What do you expect to accomplish with Physical Therapy? \_\_\_\_\_
- For this injury, Has your medical care included (check all that apply and answer related questions) :
  - Surgery: When (Specific Date): \_\_\_\_\_ What Kind? \_\_\_\_\_
  - Injection: When (Specific Date): \_\_\_\_\_ Did it help? No Yes
  - Physical Therapy: When \_\_\_\_\_ to \_\_\_\_\_ What was done? \_\_\_\_\_
  - Chiropractor: When \_\_\_\_\_ to \_\_\_\_\_ What was done? \_\_\_\_\_
  - Medication(s): \_\_\_\_\_
  - Diagnostic Imaging: X-Ray MRI CT Scan Other \_\_\_\_\_
  - Exercise: What kind: \_\_\_\_\_ Did you have any problems? No Yes, explain \_\_\_\_\_



**On the body diagram to the left, please indicate where your symptoms are located at the present time.** Use the following symbols to represent where you feel pain and/or numbness. Please do not indicate areas of pain that are not related to your present injury/condition.

● = Pain      /// = Numbness

**Please answer the following questions about your symptoms:**

- Are your symptoms: Constant Intermittent
- Are they: Getting Better Getting Worse Staying the Same
- What makes your symptoms better? \_\_\_\_\_
- Rate your pain using a pain scale (0=No Pain; 10= Most Extreme Pain):  
Worst pain rating: \_\_\_\_\_ Best pain rating: \_\_\_\_\_



## PATIENT SUMMARY LIST

### Outpatient Services

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Do you have **Diabetes**?      Yes      No

If YES, have you been hospitalized or been admitted to the emergency room in the last 6 months due to high or low blood sugar?      Yes      No

Known **Diagnosis** and **Conditions**:

\_\_\_\_\_

\_\_\_\_\_

Known Significant **Surgical** and **Invasive Procedures**:

\_\_\_\_\_

\_\_\_\_\_

Known **Allergic Drug Reactions**:

\_\_\_\_\_

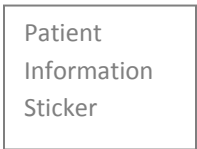
\_\_\_\_\_

Known **Medications**:

Medication(s)	Dose	Frequency	Current (✓)	Date Started	Date Discontinued

History of resistant bacteria:      Yes      No      If YES, notify infection control nurse  
 History of immunizations:      Current      Copy provided      Opt out      If Opt out, see form

Updated by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_





# Casa Colina Hospital Outpatient Center

## Missed Appointment and Late Policy

Here at Casa Colina's Outpatient Center each patient is important to us and for this reason *we request that patients do their best to attend all scheduled appointments.* We realize that occasionally an appointment needs to be cancelled and we request that all cancellations be made at least 24 hours in advance of the appointment time.

**Cancelled or Missed Appointments:** If you cancel your appointment within 24 hours or no-show for an appointment you will be charged a \$10.00 fee. A pattern of poor attendance over the course of your treatment will result in the cancellation of your future appointments. You may need to return to your physician before additional appointments are scheduled. A new prescription for services may be required.

\_\_\_\_\_ Initial

In some cases there will be a charge for missed appointments regardless of cancellation notification.

**Late Appointments:** If you arrive late for a therapy session, every attempt will be made to accommodate you. However, the appointment may be rescheduled to the next available opening on the therapists' schedule. If you arrive 15 minutes late or later for a 30 or 45 minute therapy appointment, or 30 minutes late for a 60 minute therapy appointment you may be given the option of attending the remainder of the treatment or rescheduling to another time (all applicable co-payments and cancellation fees will apply regardless of length of treatment).

*Thank you for choosing Casa Colina Outpatient Center. We appreciate your understanding and cooperation in achieving our mutual goal of maximizing the benefits of your outpatient therapy.*

*Outpatient Operations*

\_\_\_\_\_  
Patient /Guardian Signature

\_\_\_\_\_  
Date



## **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE CONDITIONS OF ADMISSION FOR OUTPATIENT SERVICES**

**For the purposes of this document, the term “patient” or “I” means the patient, the patient’s legal representative (e.g. parent, conservator, guardian, healthcare power of attorney), or residential clients of Casa Colina Hospital and Centers for Healthcare (hereafter referred to as Casa Colina).**

### **CONSENT TO MEDICAL, THERAPY, AND SURGICAL PROCEDURES**

I consent to the procedures that may be performed during this episode of care or while I am an outpatient. These may include, but are not limited to emergency treatment or services, laboratory procedures, X-ray examinations, medical, therapy, or services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and therapies is not an exact science and that diagnosis, treatment, and therapies may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination, treatment, or therapy in Casa Colina.

### **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS**

All physicians providing services to me, including the radiologist, have been granted the privilege of using Casa Colina for the care and treatment of patients, but they are not employees, representatives or agents of Casa Colina. They are independent practitioners. These physicians will bill separately for their services.

Patient initials: \_\_\_\_\_

I understand that I am under the care and supervision of my attending physician. Casa Colina and its therapy and other clinical staff are responsible for carrying out my physician’s instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, for medical, special diagnostic or therapeutic procedures, or services provided to me under my physician’s general and special instructions.

Patient Label or  
Patient Name:  
MR#:

Account #:

**FINANCIAL AGREEMENT**

I agree to promptly pay all Casa Colina bills I incur in accordance with the charges listed in Casa Colina's chargemaster and, if applicable, Casa Colina's charity care and discount payment policies and state and federal law. I understand that I may review Casa Colina's chargemaster before (or after) I receive services from Casa Colina. I understand that all physicians including the radiologist, will bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

Patient initials: \_\_\_\_\_

**ASSIGNMENT OF ALL RIGHTS AND BENEFITS**

The undersigned authorizes, whether he/she signs as an agent or as the patient, assignment and transfer to Casa Colina all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to Casa Colina of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. The undersigned agrees that the insurer or plan's payment to Casa Colina pursuant to this authorization shall discharge its obligations to the extent of such payment. The undersigned understands that he/she is financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. The undersigned agrees to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

**HEALTH PLAN CONTRACTS**

Casa Colina maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Inpatient Admissions office, the outpatient registration area, or on the Casa Colina website at [casacolina.org](http://casacolina.org). All physicians and surgeons, including the radiologist, pathologist, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if Casa Colina or the physicians providing services to me contract with my health plan. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to the patient by Casa Colina if the patient belongs to a plan that does not appear on the above mentioned list.

**FINANCIAL ASSISTANCE**

If you do not have insurance coverage, you MAY qualify for financial assistance. Casa Colina Hospital and Centers for Healthcare has a program to assist uninsured low income patients with discounted or charity care for Casa Colina services. Casa Colina may also agree to assist with setting up payment plans for those persons needing this type of assistance. For more information regarding your eligibility

Patient Label or  
Patient Name:  
MR#:

Account #:

for financial assistance, or for setting up a payment plan, please ask the Admissions or Registration Department staff for assistance, or call the Director of Patient Accounting at (909) 596-7733 Ext. 2166 or Ext. 3254.

### **CHARGEMASTER**

To provide you with information you need to make healthcare decisions, Casa Colina makes available to you Chargemaster information. The Chargemaster is a comprehensive list of all services, supplies, and procedures offered at Casa Colina Hospital and Centers for Healthcare, along with their corresponding charges. This is the master list used to create a patient's bill. Our Chargemaster is available for your review by appointment in our Patient Financial Services Department. Estimate of your bills are available upon request. Please contact Patient Financial Services for assistance at (909) 596-7733 Ext. 2166 or 3254.

### **CONSENT TO PHOTOGRAPH**

I hereby consent to be photographed while receiving treatment at Casa Colina. The term “**photograph**” as used herein, includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I understand that the images from such photography may be used for my diagnosis, treatment, or therapy, or for Casa Colina’s health care operations such as training and education programs, peer review or medical education, as my treating physician(s) or other clinical staff deem appropriate.

Photography for other purposes such as research, publication, outside education, marketing, public relations, or news or documentary requires an additional consent form be obtained.

### **PARTICIPATION IN EDUCATION PROGRAMS**

Unless Casa Colina is notified to the contrary in writing, as part of the health education program of this institution, residents and students associated with approved affiliated programs may observe or participate in patient care or in activities that support patient care. These individuals may be present during treatments and procedures and may perform limited services under the supervision of Casa Colina physicians or other qualified persons for supervision of their activities.

Patient Label or  
Patient Name:  
MR#:

Account #:

**Information on Quality of Care**

Online resources are available to you concerning the quality of care provided by hospitals and healthcare systems nationwide.

Joint Commission on Accreditation of Healthcare Organizations  
<http://www.qualitycheck.org/>

Hospital Compare  
<http://www.hospitalcompare.hhs.gov>

HealthGrades  
<http://www.healthgrades.com>

**ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

By initialing this section, I acknowledge receipt of the “Notice of Privacy Practices” of Casa Colina. The “Notice of Privacy Practices” explains how Casa Colina may use and disclose my protected health information. Casa Colina encourages me to read it in full.

Casa Colina may change the “Notice of Privacy Practices”. If the notice should change, I may obtain a copy of the revised notice by:

- Accessing Casa Colina’s website at [www.casacolina.org](http://www.casacolina.org); or
- Contacting the Admissions Department at (909) 596-7733 or toll free (866) 724-4127 ext. 3900; or
- Contacting the Outpatient Services Department at (909) 586-7733 or toll free (866) 724-4127 ext. 3500; or
- Contacting Casa Colina’s Privacy Officer at (909) 596-7733, ext. 3410

Patient initials: \_\_\_\_\_

*If it is not possible to obtain the patient or the patient’s representative’s Acknowledgement for the receipt of the Notice of Privacy Practices, describe the good faith efforts made to obtain the individual’s Acknowledgement, and the reasons why the Acknowledgement was not obtained:*

*Patient refused to sign this Acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices*

*Other:* \_\_\_\_\_

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Patient Label or  
Patient Name:  
MR#:

Account #:



Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature: \_\_\_\_\_  
(Provider Representative)

Print Name: \_\_\_\_\_  
(Provider Representative)

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or I am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient/legal representative)

If signed by someone other than patient, indicate relationship:

Print name: \_\_\_\_\_  
(legal representative)

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

Original: Health Record  
Copies: Patient (or whoever has signed the form)  
Person financially responsible (if other than the patient or whoever signed the form)

Patient Label or  
Patient Name:  
MR#:

Account #: