



PATIENT PORTAL - PATIENT INSTRUCTIONS

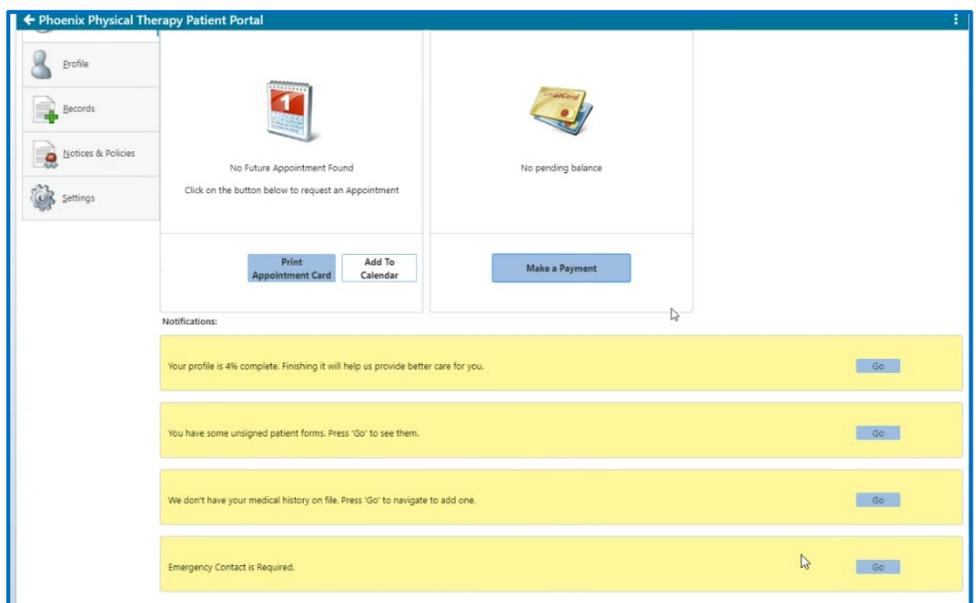
1. After receiving Welcome Email from your CACC Physical Therapy Office, ex. Aurora@cacc-pt.com, patients should login using their email address and temporary password



2. Patients may see the following notifications show:

- a. Profile needs to be completed
- b. Unsigned patient forms
- c. Incomplete Medical History
- d. Emergency contact missing

Returning patients please note that you may not have any notifications. You must select the appropriate Menu item to update information as needed, such as your contact info or Medical History.

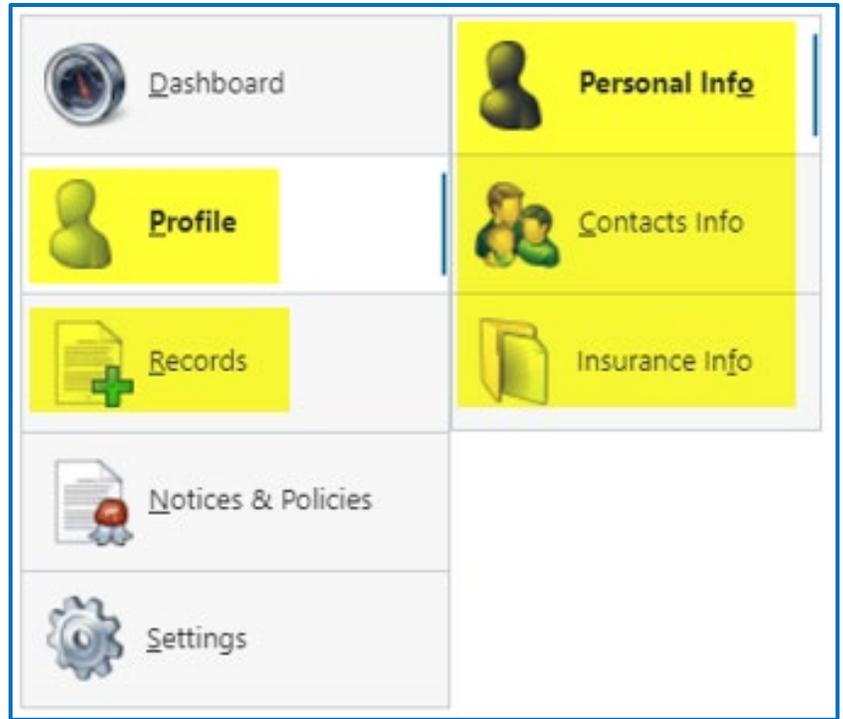




3. Important Menu Items:

a. Profile >

- i. Personal Info is where patients can complete or make any changes to their Personal Info “Demographics”
- ii. Contacts Info is where patients can add contacts
- iii. Insurance Info is where patients upload insurance card(s)



4. Records are where patients can complete their Medical History.

- a. Returning patients please go to Records > Medical History and update at least your Reason for Therapy before completing.

Dashboard	Medical History	<p>Please review and update if there are any changes. Click on the entry in the list to open your medical history.</p> <table border="1"> <thead> <tr> <th>Edit</th> <th>Last Updated</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td></td> <td>09-20-24</td> <td>Past Medical History</td> </tr> </tbody> </table>	Edit	Last Updated	Description		09-20-24	Past Medical History
Edit	Last Updated		Description					
	09-20-24		Past Medical History					
Profile	Patient Forms							
Records	Health Records							
Notices & Policies	Patient Education							
Settings	Visit Summaries							
	Upload Documents							



Medicare Secondary Payor Questionnaire:

1. As the patient answers the questions, they will automatically move to the next tab.
2. Once the patient has completed all questions, they will click the ***I've read and accept this form*** button, which will move them to the next required form.
3. **All questions must be answered.**

The screenshot shows a web-based form titled "Medicare Secondary Payor". At the top, there are navigation tabs for "Page 1" and "Page 2", with "Page 1" selected. Below the tabs, there are question numbers "1-3", "4", "5", and "6-8". A red circle with the number "1" is next to the "1-3" tab, and a red arrow points to it. The main content area contains three questions, each with "YES" and "NO" radio button options. A red box highlights the entire question area. Below the questions, there is a certification statement: "I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request that payment of authorized benefits be made on my behalf to Phoenix Physical Therapy. This authorization is valid for a period of 2 years from the date which I have signed." At the bottom, there are three buttons: "Print", "I've read and accept this form" (with a green checkmark icon), and "Save And Complete Later". A red circle with the number "2" is next to the "I've read and accept this form" button, and a red arrow points to it. A red circle with the number "3" is next to the right arrow button, and a red arrow points to it.

Acknowledgement of Receipt of Privacy Notice:

1. If a name is in the Authorized Representative you must complete the following fields:
 - a. Phone Number
 - b. Relationship to Patient: Self, Parent, Legal Guardian, etc.
2. Authorized Representative:
 - a. Phone Number
 - b. Relationship to Patient: Self, Parent, Legal Guardian, etc.
3. Restrictions field is optional

Once the required fields are completed, you will click the ***I've read and accept this form*** button, which will move the patient on to the next required form.

The screenshot shows a web-based form titled "Acknowledgment of Receipt of Privacy Notice". At the top, there are input fields for "Authorized Representative: Patient Full Name", "Phone Number: (724) 555-1234", and "Relationship to Patient: Self". A red circle with the number "1" is next to the "Authorized Representative" field, and a red arrow points to it. Below these fields is a "Restrictions" field. The main content area contains a "Purpose of this Acknowledgement" section with several paragraphs of text. At the bottom, there are three buttons: "Print", "I've read and accept this form" (with a green checkmark icon), and "Save And Complete Later". A red circle with the number "2" is next to the "I've read and accept this form" button, and a red arrow points to it.



Complete the Financial Policy and Consent:

1. Select relationship of the person signing the form as it relates to the patient – Patient, Parent/Guardian, or Authorized Representative (ex. Person with Medical Power of Attorney for the patient).
2. Click the ***I've read and accept this form*** button, which will move them to the next required form.

← Financial Policy and Consent

1 Choose signer of this form (required)

Patient Parent/Guardian Authorized Representative

We would like to **THANK YOU** for choosing Phoenix Physical Therapy (PHX PT). PHX PT accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by PHX PT. I authorize PHX PT to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic or other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue PHX PT, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses, or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

FINANCIAL RESPONSIBILITY

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all PHX PT facilities.

2 Print

I've read and accept this form

Save And Complete Later

Choose signer of this form (required)

Patient Parent/Guardian Authorized Representative

Parent/Guardian:

Choose signer of this form (required)

Patient Parent/Guardian Authorized Representative

Authorized Representative:

Phone Number: Relationship to Patient:



Complete the Signature:

1. If Patient is the signer, then patient's name will automatically populate as it appears in Raintree. If Parent/Guardian or Authorized Representative (ex. a Person with Medical Power of Attorney for the patient) is the signer, then update the Signer Name to the person signing the forms.
2. Click **Finish & Save** button to complete the required forms.

Review Completed Patient Forms:

1. In Patient Portal, click Records > Patient Forms and then click the record you want to review or finish outstanding required forms.
2. Select Dashboard, to return to the Patient Portal home page.



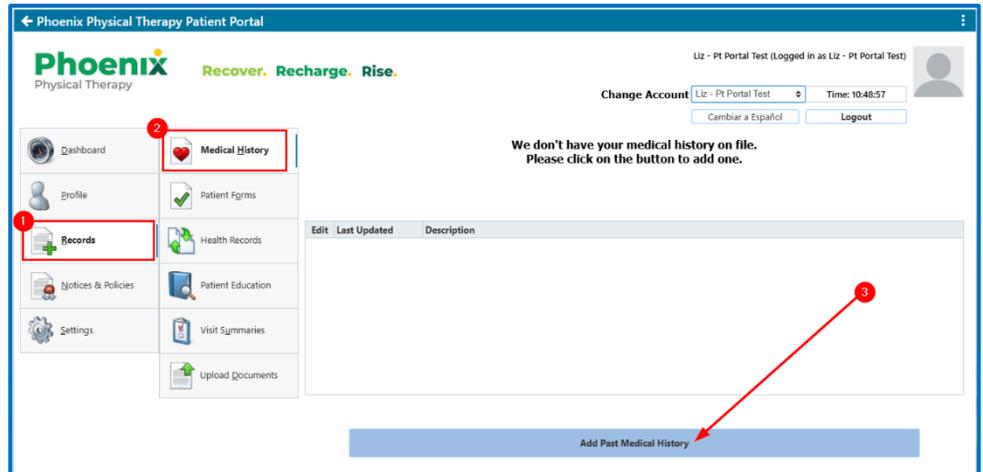
Complete Medical History:

1. For patients who need to finish their Medical History, select Records > Medical History and then click **Add Past Medical History** button.

a. New patients can also select Go from the Yellow alert box at the bottom of the Dashboard Screen.

2. For returning patients, you will need to select Records > Medical History and then

select the  icon and update the Reason for Therapy section, as well as add any other applicable details, before clicking Complete.



Patients should complete questions in each section as applicable. When you are finished filling in Medical History, select Complete.

