

PATIENT PORTAL - PATIENT INSTRUCTIONS

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

CACC Physical Therapy Patient Portal	
CACC PHYSICAL THERAPY	Login as Patient
Terms of Use Privacy Policy	Powered by 🎲 Raintree SYSTEMS

- 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.

Proteinx Physical Th				
Eecords		Constant of the second		
Notices & Policies	No Future Appointment Found	No pending balance		
Settings	Click on the button below to request an Appointment			
	Print Add To Appointment Card Calendar	Make a Payment		
	Notifications:	3		
	Your profile is 4% complete. Finishing it will help us provide better care for	you.		Go
	You have some unsigned patient forms. Press 'Go' to see them.			Go
	We don't have your medical history on file. Press 'Go' to navigate to add o	na.		Go
	Emergency Contact is Required.		ß	Go

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- 3. Important Menu Items:
 - a. Profile >
 - Personal Info is where patients can complete or make any changes to their Personal Info "Demographics"
 - 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.
 - Returning patients please go to Records > Medical History and update at least your Reason for Therapy before completing.



Dashboard	Medical <u>H</u> istory		Please review and update if there are any changes. Click on the entry in the list to open your medical history.
Profile	Patient Forms		
		Edit Last Updated	Description
<u>Records</u>	Health Records 09-20-24 Past Medical History		
Notices & Policies	Patient Education		
Settings	Visit S <u>u</u> mmaries		
	Upload <u>D</u> ocuments		



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.

← Medicare Secondary Payor	:
Page 1 Page 2	
1-3 4 5 6-8	
YES NO	
1. Are you receiving Black Lung Benefits?	
If NO, proceed to Question #2. If YES, BL is primary only for claims related to BL.	
2. Are the services to be paid by a government program such as research grant?	
If NO, proceed to Question #3. If YES, Government program will pay primary benefits for these	services
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility	y?
If NO, proceed to Question #4. If YES, DVA is primary for these services.	
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is co medical or other information about me to release to the Social Security Administration and Centers for Medicare	rrect. I authorize any holder of 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 u request that payment of authorized benefits be made on my behalf to Phoenix Physical Therapy. This authorizat	sed in place of the original and tion is valid for a period of 2
years from the date which I have signed.	
2 Print	
	3
🔇 🧭 I've read and accept this form	3

Acknowledgement of Receipt of Privacy Notice:

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

One 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.

Authorized Representative:	Patient Full Name			
Phone Number:	(724) 555-1234	Relationship to Patient:	Self	
Restrictions:				
urpose of this Acknowl	edgement			
is Acknowledgement, which allo	ws the Practice to use and/or e requirements of 45 CER \$16	disclosure personally identifiable I	realth information for treatment, payment or	health care Privacy and
countability Act of 1996 (the "Pri	vacy Regulations").	A.Szo(C/(2)(ii), part of the redefai	privacy regulations for the realist mourance	r nvacy and
understand and acknowledge t	hat I am consenting to the us	se and/or disclosure of personally	identifiable health information about me by	PHX PT. (the
ermitted in the Privacy Regulation	ting me, optaining payment to 19.	r treatment of me, and as necessa	ary in order to carry out any nealth care oper	ations that are
I am aware that the Practice mai	ntains a Privacy Notice which	sets forth the types of uses and d	sclosures that the Practice is permitted to m	ake under
e Privacy Regulations and sets for inderstand and acknowledge that	orth in detail the way in which I have received a copy of the	the Practice will make such use o Privacy Notice.	r disclosure. By signing this Acknowledgeme	int, I
I understand and acknowledge th	nat in its Privacy Notice, the P	ractice has reserved the right to cl	ange its Privacy Notice as it sees fit from tir	ne to time. If I
O Box 392977, Pittsburgh, PA 15	251-9977 Attention: Complian	request for a revised Privacy Notic ice.	to the onice of the Practice at the following	g address.
I understand and acknowledge th	hat I have the right to request	that the Practice restrict how my in	formation is used or disclosed to carry out to	reatment,
ry limited circumstances as desc	cribed in the Privacy Notice, bi	ut if the Practice agrees to such a	requested restriction, it will be bound by that	restriction
request the following restriction	ns be placed on the Practice	e's use and/or disclosure of my	health information (leave blank if no res	trictions):
Y SIGNING THIS FORM LACK	OWLEDGE THAT I HAVE BE		OF THIS ACKNOWLEDGEMENT AND A C	OPY OF THE
RACTICE'S POLICY NOTICE AI	ND AGREE TO THE PRACTIC	CE'S USE AND DISCLOSURE OF	MY PROTECTED HEALTH INFORMATIO	NFOR
REATMENT, PATMENT AND HE	ALTH CARE OFERATIONS.			
		Print Print		
	4	W		

Save And Complete Later

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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	:
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.	
Print	
Save And Complete Later	
Choose signer of this form (required)	
Patient Parent/Guardian Authorized Representative	
Parent/Guardian: Parent Test	
ner of this form (required)	
t Parent/Guardian • Authorized Representative	
vrized Representative: Authorized Rep Test	
Phone Number: (757) 555-1234 Relationship to Patient: Person w/ Med Power Att.	



Complete the Signature:

- 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.



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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	+ Phoenix Physical Therap	oy Patient Portal			:
	Dashboard, to	Phoenix Physical Therapy	Recover. Re	charge. Rise.		Liz - Pt Portal Test (Logged in as Liz - Pt Portal Test)
	Detient Dentel			-	Chang	e Account Ltz - Pt Portal lest Time: 09:56:10
	Patient Portal			3		
	home page.	Dashboard	Medical <u>H</u> istory		Please review and sign the forms below	. Click on the form in the list to open it.
		2 Profile	Patient Forms	Edit Date	Description	Status Decline
			V I diletti I gitti s	II-26-24	Acknowledgement of Privacy Notice	Unsigned
		Records	Health Records	E 11-26-24	Financial Policy and Consent	Unsigned
				11-26-24	Financial Policy and Consent	Signed
		Notices & Policies	Patient Education	II-26-24	Acknowledgement of Privacy Notice	Signed
		~~L	3	I 1-26-24	Medicare Secondary Payer	Signed
		Settings	Visit Summaries			
		[Upload Documents			
				۵ ۱		
				Chatra Lange d		
				Not Available - Form not	available to sign	
				Signed - Form is signed		
				Accepted - Form is mark	ed accepted	
				Unsigned - Form is not s	igned	
				Fill/Review - Form is not	accepted or declined and is not available to sign	



Complete Medical History:

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

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- Past Medical History button.
 - a. New patients can also select Go from the Yellow alert box at the bottom of the Dashboard Screen.
- 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.

Phoenix Physical Therapy	Recover. Rec	harge. Rise.	Change a	Liz - Pt Portal Test (Log Account Liz - Pt Portal Test Cambiar a Español	ged in as Liz - Pt Portal Te Time: 10:48:57 Logout	st)
	Medical <u>H</u> istory		We don't have your me Please click on the bu	lical history on file. Itton to add one.		
Profile	Patient Forms					
Records	Health Records	Edit Last Updated	Description			
Notices & Policies	Patient Education				_3	
Settings	Visit S <u>u</u> mmaries					
	Upload Documents					
			Add Past Medic	al History		

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

Save	Patient Information
•	Patient Liz - Pt Portal Test MR # 00427869 DOB 02-21-93 Age 31
Reason for Therapy	
Medical Conditions	Reason for Therapy
Surgeries	When did the condition begin?*
Medications	Is this a work related injury? Yes No
Allergies	Date of next doctor appointment for this condition
Living Arrangements	
Social History	Current Symptoms
Work	Rate symptom intensity in the past 5 days
Equipment	Symptoms at worst 🗘 Symptoms at best
Feeding	
Memory	(0 is no pain or symptoms and 10 is the worst possible pain or symptoms)
Speech	Surgery
<u>C</u> omplete	Type of surgery (if applicable) Did you have surgery for this condition? Ves No Date of surgery (if applicable)
	How do activities change the symptoms?
	Please list the activities that make your Please list the activities that make your What activities can you no longer d symptoms worse symptoms better this condition?

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