PATIENT INFORMATION FORM

Patient's Name_____D.O.B._____Sex____Soc.Sec.#_____

Home Address_____Phone #: _____ Ok to leave message
Number & Street Apt #: City/Town State Zip

Work #: _____ Email _____ Prefer no emails

Cell #: _____ Ok to leave message/Text Appointment Reminders - Service Provider _____ Prefer no text messages

Emergency Contact: _____Phone_____Relationship _____

Referred by: _____Phone_____

Disclosure of Information: I grant Physical Therapy Specialists permission to disclose all information to the following:

_____ Phone _____Relationship_____

Financial Responsibility Information:

Health Insurance_____Worker's Comp. Insurance_____ Medicare_____Other_____

Insurance Information:_____Phone_____

Secondary Insurance _____Phone_____

Injury Information: Is your injury related to work?( ) an auto accident?( )

Explain in detail please:_____

Attorney Information:_____Phone_____

Past medical history:

1. Please list surgeries and recent hospitalizations / other conditions:

   _____

   _____

2. Please list recent diagnostic studies (Cat-Scan, MRI, X-Rays)_____

3. Do you have any metal anywhere in your body; pins/plates post fracture, or pacemaker (other than teeth)? Yes No
   Describe: _____

4. Have you ever taken steroids or anti-coagulants for an extended period of time? No Yes

5. List any medications you are now taking:_____

6. Have you ever had home health care for **this condition**? Yes No
   If yes, please indicate when you were discharged: _____

PATIENT FINANCIAL POLICY

We participate with *most* commercial U.S. insurance plans. The following list includes some but not all of the plans with which we are out of network**: Bella Vista, Benesight, Cigna, Individual Blue Shield Plans, El Protecto Del Barrio, Global Care, Healthcare LA, Humana, Medi-Cal, Mission Community, Oxford, Pacificare, United Healthcare, Universal Smartcomp, and Watts Healthcare.** Please double check with your insurance company in regards to your out of network options/benefits and in network benefits including:

A. The annual deductible
B. Co-payments or Co-insurance amounts for office visits
C. Authorization requirements

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

As a courtesy, we will verify your benefits with your insurance company. We are sometimes quoted incorrect benefits and therefore, it is the **patient's** responsibility to know the plan benefits including authorization requirements and plan exclusions. Should we be misquoted, you will be billed for the proper amount.

Most plans have a limit on the number of visits for physical therapy. It is the **patient's** responsibility to know that number and to make sure that it is not exceeded. Should you go over the limit, you will be billed for the visit.

Should your account end up in our collections department for any reason, you will incur a $15.00 fee.

Cancellation Policy: You must arrive 10 minutes prior to you scheduled appointment to prepare for treatment. We request that you please give at least 1 business days notice if a cancellation is necessary to avoid a **$75 charge**.

Cedars HMO: Copay is due at the time of service. Copay is determined by the Cedars Sinai Website, if we are informed that the amount is incorrect, we will bill you for the correct amount.

Medicare:
We participate and accept assignment with the Medicare program. Patients are responsible for meeting their annual deductible ($226 for the year 2023) and paying the 20% co-payment. We will file with your secondary insurance. In the event that your insurance carrier fails to pay for services or does not pay the full 20%, you will be billed for the unpaid charges.

Medicare will NOT cover physical therapy if you are receiving any home health care services (i.e. a nurse, aide, or therapist coming to your house for ANY reason) **even if it is not related to the reason you are in physical therapy** . This includes blood pressure check, injections, medications, etc. If denied by Medicare, you will be responsible for the visit.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____
Patient/Responsible party signature Date

Physical Therapy Specialists
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Physical Therapy Specialists LEGAL DUTY

Physical Therapy Specialists is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Physical Therapy Specialists uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Physical Therapy Specialists may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physical Therapy Specialists may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physical Therapy Specialists policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Physical Therapy Specialists will obtain your written authorization before selling any patient information. Any other uses and disclosures not described in the notice will be made only with authorization.

Physical Therapy Specialists will notify any person affected should there be a breach of patient health information.

Physical Therapy Specialists may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You have the right to restrict disclosures of information to health plans in situations where you have paid out of pocket in full for the healthcare service.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physical Therapy Specialists will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Physical Therapy Specialists may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our privacy office at Physical Therapy Specialists 310-273-8256. You may also send a written complaint to the US Department of Health and Human Services.

Effective April 1, 2003

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Physical Therapy Specialist's Notice of Information Practices. I understand that Physical Therapy Specialists may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Physical Therapy Specialists will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy Specialist's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Patient Name Signature

_____

Date

Financial Agreement: I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed directly to: Physical Therapy Specialists, Inc. 200 N. Robertson Boulevard, Suite 301 Beverly Hills, CA 90211

The professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

If treatment received is for a personal injury where a third party insurance or attorney is involved, I agree to sign a lien against any settlement received by me and/or my attorney. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me, I/we agree to pay reasonable attorney's fees and/or other such costs as the Court determines proper.

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I have Insurance coverage, I authorize my insurance company named above to process and pay all claims for services rendered. I understand that if for any reason my insurance company does not pay Physical Therapy Specialists for authorized services, I am financially responsible and will pay Physical Therapy Specialists Inc. on behalf of my insurance company, from whom I will seek reimbursement after canceling my debt with Physical Therapy Specialists Inc.

I understand there are potential risks as well as benefits from physical therapy and I have been approved by my physician to receive physical therapy. Risks include, but are not limited to muscle sprain/strain from exercise; exacerbation of current problem/soreness following treatment from therapist/massage therapist; falls associated with balance training; burns from hot packs/cold packs or electrical modalities; cardiac risks associated with exertion of exercise.

I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that I assume the risk associated with coming into a physical therapy office and should I contract the COVID-19 virus, I agree that I or any person accompanying me will not initiate legal action in any form or manner or see any type of compensation from Physical Therapy Specialists Inc., its employees, or contractor.

I agree that I will not come in if I have any known exposure to COVID-19 or I exhibit any of the following symptoms: shortness of breath, dry cough, fever, runny nose, or sore throat and agree to follow all safety guidelines that the office has in place. I agree to notify the physical therapy office immediately if I become ill with COVID-19 symptoms or test positive for COVID-19. If positive test, I understand that proof of two negative tests to return to in office PT.

Signature of Patient _____ Date of Signing _____

Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Physical Therapy Specialists reserves the right to charge a fee of $75.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with 1 business day advance notice.

This fee is not covered by insurance and is the patient's responsibility. It must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature