SOUTH OC PT
South Orange County Physical Therapy

PATIENT INFORMATION

Patient Name*: _____ Date of Birth*: _____

SSN#*: _____ Gender*: ▫ F ▫ M Marital Status: ▫ Single ▫ Married Student? ▫ Yes ▫ No

Address*: _____ City, State, Zip*: _____

Primary Phone*: _____ Home / Cell / Work Secondary Phone*: _____ Home / Cell / Work

Email Address*: _____

Employment Status: _____ Occupation: _____ Employer: _____

Employer Address: _____ City, State, Zip: _____

Emergency Contact Name*: _____ Relationship*: _____

Primary Phone*: _____ Home / Cell / Work Secondary Phone*: _____ Home / Cell / Work

Address*: _____ City, State, Zip*: _____

FINANCIALLY RESPONSIBLE PARTY - If not patient, must be present

Name*: _____ Relationship*: _____

Date of Birth*: _____ SSN#*: _____ Gender: ▫ F ▫ M

Address*: _____ City, State, Zip*: _____

Primary Phone*: _____ Home / Cell / Work Secondary Phone*: _____ Home / Cell / Work

HOW DID YOU HEAR ABOUT SOUTH OC PT?

- ▫ **Doctor Referral** Name: _____
- ▫ **Friend/Family** Name: _____
- ▫ **Event** Name: _____
- ▫ **Workshop** Name: _____
- ▫ **Building Signage**
- ▫ **Facebook Page / Facebook Ad** Circle which
- ▫ **Google**
- ▫ **Yelp**
- ▫ **Blog/Newspaper Article**
- ▫ **Other**: _____

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PATIENT MEDICAL HISTORY

Patient Name: _____ D.O.B: _____

Reason for Physical Therapy: _____

_____

_____

Was this work related? ▫ Yes ▫ No Was this auto-accident related? ▫ Yes ▫ No

Describe onset of condition: _____

_____

_____

Date of Injury/Onset: _____ Surgical Date: _____ Name of Surgeon: _____

Type of pain: ▫ Sharp ▫ Burning ▫ Aching ▫ Tingling ▫ Numbness ▫ Other: _____

Rate your current pain level: 1 (minimal) to 10 (severe): _____ Does your pain radiate? ▫ Yes ▫ No

Does rest relieve your pain? ▫ Yes ▫ No Does pain ever awaken you? ▫ Yes ▫ No

What aggravates your pain most? ▫ Sitting ▫ Standing ▫ Walking ▫ Other: _____

Which position is most comfortable? _____

Are you currently on any medications? ▫ Yes ▫ No If yes, please list: **Please list on page 8**

Are you currently or have you ever experienced any of the following:

Diabetes ▫ Yes ▫ No	Cancer ▫ Yes ▫ No	Metal Implants ▫ Yes ▫ No
High Blood Pressure ▫ Yes ▫ No	Stroke ▫ Yes ▫ No	Shortness of Breath ▫ Yes ▫ No
Heart Disease ▫ Yes ▫ No	Heart Murmur ▫ Yes ▫ No	Asthma ▫ Yes ▫ No
Pacemaker ▫ Yes ▫ No	Kidney Problems ▫ Yes ▫ No	Heart Arrhythmia ▫ Yes ▫ No
Headaches ▫ Yes ▫ No	Currently Pregnant ▫ Yes ▫ No	Previous Surgery ▫ Yes ▫ No
Seizures ▫ Yes ▫ No	Allergies ▫ Yes ▫ No	Previous PT ▫ Yes ▫ No

Have you had any of the following tests for this injury: ▫ X-Rays ▫ MRI ▫ CT Scan ▫ EMG ▫ Other: _____

If yes to any of the above, please give approximate dates: _____

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PATIENT FINANCIAL AGREEMENT

Keeping the lines of communication open with our patients on all matters is a key focus at South OC PT. The following are the financial policies and expectations for our office. Please read this section carefully and sign below. If you have any questions, please ask our office staff for clarification.

- Upon arrival to our office, please check in with the front desk and inform them of any changes to your insurance coverage, contact information or payment information.

- As a courtesy to you, we will verify your insurance coverage. However, it is the responsibility of you, the patient, to be aware of your benefit details. **According to all insurance carriers, a verification of benefits is not a guarantee of coverage or payment.** This means that you, the patient or guarantor, are ultimately responsible for the cost of your treatment.

- We require a credit card to be kept on file with our office. For your privacy and protection, this credit card information is kept on a secure third-party website, and we only keep the last four digits. This card can be charged for the following reasons:
    - Visit payment is not collected from you at the beginning of your visit.
    - No-Show or late-cancellation charges.
    - Insurance discrepancies that are not resolved within 60 days of the date of service.

- All visit payments are due before the start of your treatment each visit.
    - We do our best to estimate the amount that your insurance plan will apply to your deductible, copay and/or co-insurance or hold you, the patient, responsible for each visit. If your insurance company deems you responsible for an amount that differs from what we estimated, this will be considered your, the patient's, responsibility and will be billed to you, the patient.

- There will be a $35 fee charged for all checks returned for insufficient funds.

- Should we have to send your unpaid bill to collections, we will add a service fee of 50% to your total bill.

- There will be **NO refunds** for any reason on any services, packages, and/or memberships. By making a purchase with South OC PT, you are confirming that you have read and understand our no refunds policy.

By signing below, I agree that I have read and understand this patient financial agreement. I agree to comply and accept responsibility to the terms outlined above.

Patient Name*: _____ Signature*: _____ Date*: _____

Guarantor Name*: _____ Signature*: _____ Date*: _____
(If different from patient)

SOUTH OC PT
South Orange County Physical Therapy

APPOINTMENT CANCELLATION POLICY

- South OC PT requires a 24-hour cancellation and rescheduling notice.
- A $50 charge will be assessed for all no-show or late cancellations.
- We understand that circumstances can arise that do not allow for 24 hours of notice, however please always give our office a call at your earliest convenience so that others may fill your appointment spot.

Thank you in advance for your cooperation!

By signing below, I agree that **I have read and understand the appointment cancellation policy, and I agree to comply and accept responsibility to the terms outlined above.**

Patient Name*: _____ Signature*: _____ Date*: _____

PHONE & EMAIL COMMUNICATION APPROVAL

In the instance that I am unable to answer my phone, I give South OC PT permission to leave a detailed message or email in regards to any medical or billing information pertaining to myself.

Patient Name*: _____ Signature*: _____ Date*: _____

SOUTH OC PT
South Orange County Physical Therapy

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review carefully.

South Orange County Physical Therapy's Legal Duty
South OC PT is required 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
South OC PT uses your personal health information primarily for treatment, obtaining payment for treatment, and evaluating the quality of care that we provide, as well as for internal administrative activities; for example, we may use your personal health information to contact you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related services that could be of benefit to you.

South OC PT may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our 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.

South OC PT 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 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 for reasons other than treatment, payment or other related purposes. 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 emergency circumstances.

Concerns and Complaints
If you are concerned that we 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 officer. You may also send a written complaint to the US Department of Health and Human Services.

Acknowledgement of Patient Information Privacy Practices
I have read and fully understand South Orange County Physical Therapy's Notice of Patient Information practices. I understand that South OC PT 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 hereby consent to the use and disclosure of my personal health information for purposes as noted in South OC PT's Notice of Patient Information Privacy 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*: _____

Guarantor Name*: _____ Signature*: _____ Date*: _____
(If different from patient)

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INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. South OC PT cannot guarantee what your reaction will be to a specific treatment, nor can it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

Please note the following patient rights:

1. It is your right to decline any part of your treatment at any time before or during treatment should you feel any discomfort or pain or have other unresolved concerns.

2. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.

3. It is your right to discuss the potential risks and benefits involved in your treatment.

By signing below, I agree that I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name*: _____ Signature*: _____ Date*: _____

Witness Name*: _____ Signature*: _____ Date*: _____

SOUTH OC PT
South Orange County Physical Therapy

MEDICARE BENEFICIARY/ ADVANTAGE PLAN ONLY

Patient Name: _____ Date: _____

As per Medicare guidelines we are required to assess any risk for falls and provide an appropriate plan of care or advice for assistive device.

1. Have you had two or more falls in the past year? ▫ Yes ▫ No
   If yes, when? _____
2. Were there any injuries caused by these falls? ▫ Yes ▫ No
   If yes, in what area? _____

Height: _____ Blood Pressure: _____ Weight: _____ Systolic / Diastolic: _____ / _____

Thank you for your cooperation!

SOUTH OC PT
South Orange County Physical Therapy

MEDICARE BENEFICIARY/ ADVANTAGE PLAN ONLY

Patient Name: _____ D.O.B: _____

MEDICATIONS/ SUPPLEMENTS/VITAMINS	DOSAGE	FREQUENCY

SOUTH OC PT
South Orange County Physical Therapy

STATEMENT OF FINANCIAL RESPONSIBILITY

For Medicare Beneficiaries/ Advantage Plans only

I, _____, understand that I will be invoiced by South Orange County Physical Therapy for any deductible not met by me or my supplemental insurance carrier.

If I have supplemental/secondary insurance coverage, my deductible will be billed to this insurance carrier. In the event my secondary insurance does not cover the deductible, I will receive an invoice from South OC PT for my deductible amount for which I am financially responsible.

Medicare will not pay for physical therapy services while I am receiving **Home Health Care**. If it is determined that I am currently receiving, or recently received, Home Health Care and have not yet been discharged, I will be responsible for the cost of services provided by South OC PT.

If you are receiving physical therapy at another location please be aware that Medicare only allows a set dollar amount per calendar year.

Have you received physical therapy **this year** prior to this visit? ▫ Yes ▫ No

If yes, how many visits? _____

If you are receiving treatment at two locations, you may exceed your Medicare cap, at which point you may be financially responsible for the cost of treatment.

Are you currently receiving physical therapy treatments at a different facility? ▫ Yes ▫ No

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I understand and acknowledge my financial responsibility in the above statements.

Patient Name*: _____ Signature*: _____ Date*: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
HOME HEALTH CARE	**Medicare does not cover out-patient services while patient is receiving home healthcare.**	**$80-100/visit**
Exhausted Cap Amount:	**Your medical benefits are capped to a yearly maximum for therapy services & any amount above & beyond that can be denied if not justified as medically necessary.**	
Therapy services-Maintenence		**$80-100/visit**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: