

PACIFIC PHYSICAL THERAPY
14650 Aviation Blvd., Suite 100
Manhattan Beach, CA 90250

Date: _____

Referring Doctor: _____

PLEASE PRINT CLEARLY

Email Address: _____

First Name: _____

Home Phone: _____ Cell: _____

Last Name: _____

Birth Date: _____

Address: _____

Social Security #: _____

City, St., Zip: _____

Sex: _____ Age: _____

Single _____

Married _____

Widowed _____

Separated _____

Divorced _____

Employer: _____

Occupation: _____

Address: _____

Work Phone: _____

City, St., Zip: _____

Drivers License #: _____

Date last worked: _____

Has your employment terminated? _____

Name of spouse or legal guardian: _____

Employer: _____

Birth Date: _____

Address: _____

Work Phone: _____

City, St., Zip: _____

Social Security #: _____

May we leave voicemail messages regarding your appointments at your home and place of employment?

Home: Yes _____ No: _____

Work: Yes _____ No: _____

Cell: Yes _____ No: _____

How did you learn of our practice? _____

Have you ever been in this office before? Yes _____ No _____ How long ago? _____

Please Complete the Following Information about your Injury:

Date of Accident

Insurance Carrier

Adjuster's Name/Phone Number

Work Related _____

Auto Accident _____

Other, Please Describe _____

PATIENT HISTORY

Please completely fill out the following questions. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Name: _____ Date: _____

Birth date: _____ Occupation: _____

Date of Injury or Onset of Complaint(s): _____
(Please give approximate date if not sure)

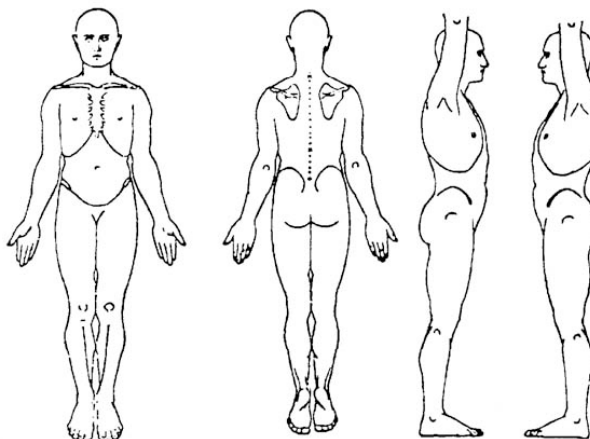
Where were you injured? Work: _____ Home: _____ Other: _____

Briefly describe how you were injured or how complaints began (i.e. after gardening, lifting)?

Where is your pain/injury located?:

Please use the drawing to indicate _____
the location of your pain/injury.

List all over-the-counter and Prescription medications you are currently taking for any reason: (include pills, injections, etc.)



If you have any metal or other implants in your body, please describe where they are:

Have you had any treatment for this condition? Yes: _____ No: _____
If yes, please describe:

MEDICARE PATIENT ONLY:

Have you had any home therapy for this or any other condition currently or within the last three months? Yes: _____ No: _____

If yes, circle one: P.T. / O.T. And Start/End Date: _____

Please mark any of the following diagnostic studies completed for this condition:

X-Rays
 MRI
 Other

Electromyography (EMG)
 Computed Tomography (CT Scan)

Have you ever been diagnosed with any of the following: (Circle YES or NO for each item)

YES NO Cancer
 If yes, please describe: _____
 YES NO Heart Attack
 YES NO Other heart Conditions
 If yes, please describe: _____

YES	NO	Pacemaker
YES	NO	High Blood Pressure
YES	NO	Respiratory Problems
YES	NO	Asthma
YES	NO	Emphysema
YES	NO	Thyroid Problems
YES	NO	Diabetes
YES	NO	Multiple Sclerosis
YES	NO	Rheumatoid Arthritis
YES	NO	Other Arthritic Conditions
YES	NO	Stroke
YES	NO	Deep Vein Thrombosis (Blood clot)
YES	NO	Other If yes, Describe: _____ _____

YES	NO	Kidney Disease
YES	NO	Anemia
YES	NO	Epilepsy
YES	NO	Eye/Vision Problems
YES	NO	Emotional/Psychological Problems
YES	NO	Sleep Problems
YES	NO	Headaches
YES	NO	Hepatitis
YES	NO	Tuberculosis
YES	NO	Osteoporosis
YES	NO	Pregnant, or think you might be.
YES	NO	HIV

Please list any surgeries or other conditions for which you have been hospitalized, include the approximate date and the reason for the surgery or hospitalization.

<u>Date</u>	<u>Surgery/Hospitalization</u>	<u>Reason</u>

Do you smoke tobacco? Yes _____ No _____ If Yes, how much per day? _____

What are your goals for physical therapy?

Pacific Physical Therapy

14650 Aviation Blvd., Suite 100 | Manhattan Beach | CA | 90250
Phone: 310.725.8505 | Fax: 310.725.8509 | www.PacificPhysicalTherapy.com

Summary of Financial Policies

As you begin your course of therapy with us, we want to be very clear about our policies and procedures regarding payment and the financial aspects of your care.

- **Cancel or No-show:** There is a \$75 charge for a no-show, or for the cancellation of an appointment with less than 24 hour notice.
- **Typical Fees:** The typical fee for an initial evaluation and treatment is \$180. The typical fee for follow-up treatments is \$150. Supplies are additional. These typical charges are prior to any negotiated contract adjustment applied by your insurance company.
- **Insurance Billing:** As a courtesy to you, we bill your insurance carrier once each week and make every reasonable effort to assist in expediting insurance payment. Some insurance companies pay claims quickly and completely. Some pay slowly and only in part or not at all. ***You are ultimately responsible in making sure your insurance company makes appropriate payment. When we are in network payments go directly to Pacific Physical Therapy. If we are out of network, payments may come to you. For out of network care we require payment at the time of service.***
- **Co-Pays:** Co-pays are due at the time of service. We are required to collect co-pays since they are an integral part of the agreement between you and your insurance company.
- **Co-Insurance:** We will estimate your portion and collect payment at the time of service. We have found this works much better for everyone and reduces surprises at the conclusion of therapy while spreading the payments out over the course of care. Any under payments will be your responsibility. Any overpayments will be promptly refunded once all dates of service are paid by the insurance company.
- **Monthly Statements:** You will receive monthly statements from our billing company whenever a patient balance is outstanding. You may receive monthly statements if your insurance company is not paying in a timely manner. All charges are due and payable within 60 days unless special arrangements have been made.
- If you have any questions or need to make special arrangements please notify us immediately or contact our billing service at 877.851.0121.

Acknowledgement of Responsibility by Patient or Guardian of Patient:

The undersigned accepts financial responsibility to Pacific Physical Therapy for services rendered under the terms listed above. Should the account be referred for collection or legal matters, the undersigned will pay collection, legal and/or attorney fees/expenses in addition to the amount due for services rendered.

I have read the information above and understand that I am solely responsible for payment on my account.	
Patient Signature (if minor, signature of parent/guardian)	Date:

PACIFIC PHYSICAL THERAPY

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.

PACIFIC PHYSICAL THERAPY'S LEGAL DUTY

Pacific Physical Therapy 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, Pacific Physical Therapy 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.

Pacific Physical Therapy 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, Pacific Physical Therapy's 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 further disclosures at any time.

Pacific Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. 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 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. Pacific Physical Therapy 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 Pacific Physical Therapy 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 practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Pacific Physical Therapy's health information practices, or if you have a complaint, please contact the following person:

Kathy McElroy, M.A., P.T.
Pacific Physical Therapy
14650 Aviation Blvd., Suite 100
Manhattan Beach, CA 90250
Telephone: 310-725-8505 ***Fax: 310-725-8509***

Pacific Physical Therapy

In general the HIPPA privacy rule gives individuals the right to request a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number that you have provided us on your patient sheet.

Home Telephone (_____) _____

- Okay to leave message with detailed information.
- Leave message with call back number only.

Cellular Telephone (_____) _____

- Okay to leave message with detailed information.
- Leave message with call back number only.

Work Telephone (_____) _____

- Okay to leave message with detailed information.
- Leave message with call back number only.
- Okay to fax to (_____) _____

Written Communication

- Okay to mail to my home address
- Please mail to another address

The Privacy Rule Generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for used or disclosures made pursuant to an authorization requested by the individual.

Record of Disclosures of Protected Health Information

I, _____ authorize the office of Pacific Physical Therapy, to contact the following person(s) in regard to my medical information.

Name/Relationship

Name/Relationship

Name/Relationship

Name/Relationship

Patient Signature

Patient Name

Birth Date

Date