Orthosport Physical Therapy

www.orthosportpt.net

PATIENT INFORMATION FORM

Patient's Name: _____ D.O.B._____ Sex___ Soc.Sec #_____
Last First M.I.

Home Address_____ Mobile Phone # _____
Number & Street City/Town State Zip

Carrier: _____

Home Phone #: _____

Email Address_____ ☐ Prefer no emails

_____
If patient is a minor, list policy holder's name Phone # Social Security Number

Emergency contact: _____Relationship_____ Phone _____

Referred by: _____Phone _____

Financial Responsibility Information:

Health Insurance____Worker's Comp. Insurance____ Medicare____Other_____

Please provide this office with copies of the following cards: Health Insurance Card & Drivers License

Injury Information: When did your condition begin? (Date of injury)_____
Is your injury related to work? (yes / no) An auto accident? (yes / no) Personal injury? (yes / no)

Explain in details 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. Have you ever had home health care for **ANY** condition? YES NO
   If yes, please indicate when you were discharged: _____
4. List all medication, vitamins and supplements that you are taking:

Name: Dosage / Frequency: For what condition

_____

_____

_____

_____

_____

TREATMENT AND FINANCIAL POLICIES

Thank you for entrusting Orthosport Physical Therapy with your treatment. We operate under the following policies:

_____ **Release of Medical Record(s):** In order to facilitate your treatment, we request that all of your medical records relevant to treatment be released to Orthosport Physical Therapy. A copy of this release shall be considered to be as valid as the original. We may use and disclose medical information about you to provide you with medical treatment or services, for payment purposes, and for our health care operation. You have been given a copy of our privacy notice. You also have the right to request restrictions on how information about you may be used and disclosed for treatment, payment, and health care operations. This release shall be in effect until revoked.

_____ **Consent for Care:** You understand that your therapists will discuss with you your diagnoses, treatments, risks, benefits and reasonable expectations for desired results. You are expected to ask any questions you may have regarding the information, so you will have an understanding of the information provided. You hereby give your consent to the staff of Orthosport Physical Therapy to provide therapy care and services prescribed by your physician, both verbally and written, and to exercise professional judgment regarding any additional care and services that may be necessary.

_____ **Appointment/ Compliance:** Arrive 5-10 minutes prior to your appointment time, and sign in upon your arrival. If you are late, your therapist reserves the right to reduce your treatment time at his/her discretion. **There is a $50 charge for no-show or cancellations without a 24-hour notice.** You will be held responsible for the fee and your credit card will be charged.

_____ **Workers Compensation Insurance**: We will request authorization from your workers compensation insurance carrier on your behalf. You will not be responsible for costs incurred by the authorized treatment. You agree that Orthosport Physical Therapy release your medical record to your insurance company for billing purposes. We are also obligated to inform your insurance carrier if appointments are not kept or compliance with your program is not met.

_____ **Medicare Insurance:** We accept Medicare assignment and will bill Medicare for you. If you have Medicare as your only insurance coverage, you are responsible for the 20% co-payment as well as any deductible. By law, you will be billed for any co-payment or deductible after we receive the Medicare Explanation of Benefits. If you have a secondary insurance, we will file with your secondary insurance out of courtesy. However, in the event that your insurance carrier fails to pay for the services or does not pay the full 20%, you will be billed for the unpaid charges (see *"Other Insurance"* for more information).

MEDICARE WILL NOT COVER PHYSICAL THERAPY IF YOU ARE RECEIVING ANY HOME HEALTH CARE SERVICES (I.E. A NURSE OR THERAPIST COMING TO YOUR HOUSE FOR ANY REASON) THIS INCLUDES BLOOD PRESSURE CHECK, INJECTIONS, MEDICATIONS, ETC. IF DENIED BY MEDICARE, YOU WILL BE HELD RESPONSIBLE FOR THE VISIT.

_____ **Private Insurance Plan**: As a courtesy to you, our office will contact your insurance company to request information regarding your deductible, co-payment, and the terms of coverage for your services. We will inform you of the quote given to us, but it is not a guarantee of payment. We encourage you to call your insurance company periodically to check for your coverage and changes in your benefits.

Payment policy: As a courtesy to you, we will verify benefits, bill, and collect from your insurance, but it is **patient responsibility** to contact their insurance provider and know their benefits. It is also **patient responsibility** to pay for services rendered. Your insurance policy is a contract between you and your insurance carrier; Orthosport Physical Therapy is not a party to that contract. If your insurance carrier does not remit payment within 45 days, the patient is responsible for the outstanding balance. This includes co-payments, deductibles and any percentage that insurance does not cover. Please be aware that some of the services provided may be non-covered services. Non-covered services are services your medical insurance may deem unreasonable or unnecessary. We reserve the right to charge up to 4% interest per month on balances outstanding more than 45 days from billing, but not in excess of the maximum interest allowed by law. Our company policy is to **collect all co-payment and deductible at the time of check in**. Some co-payments are pre-set and some are estimates. A statement will be sent if a patient balance should occur after insurance payment. If it becomes necessary for the account to be referred to an attorney for collection or suit, you are liable for reasonable attorney's fees and collection expenses. There is a $25.00 fee for returned checks.

I hereby consent the release and disclosure of my personal health information to:

Dr:_____

Insurance Company:_____

Please sign below, indicating that you have received a copy of this notice and you have read, understand and agree to the terms set forth. By your signature, you further agree to final and binding arbitration for any and all claims, disputes or controversies arising between you and Orthosport Physical Therapy, whether contractual, statutory or common law. You additionally agree to waive your rights to a jury trial and to utilize the services of, and to arbitrate under the rules communicated by the American Arbitration Association.

_____	_____	_____
Signature of Patient	Print Name	Date

Orthosport 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.

Orthosport Physical Therapy's **LEGAL DUTY**

Orthosport Physical therapy is required by law to protect the privacy of your personal health information, provide a notice of our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Orthosport 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, *Orthosport Physical Therapy* may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, and/ or other health related benefits that could be of interest to you.

Orthosport 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, *Orthosport 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 future disclosures at any time.

Orthosport 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 will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at anytime.

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. Orthosport 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 Orthosport 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 US Department of Health and Human Services. For further information on Orthosport Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Orthosport Physical Therapy
Office Administrator
10190 Culver Blvd. Culver City, CA 90232
Telephone: 310-837-9700 Fax: 310-837-9701

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10190 Culver Blvd. Culver City, CA 90232
Tel: (310) 837-9700 Fax: (310)837-9701
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Dear New Patient:

Welcome to Orthosport Physical Therapy!

Thank you for choosing our facility to meet your rehabilitation needs. We are pleased to meet you and would like to make your time here a pleasant and enjoyable experience.

The Orthosport team is here to assist you in advancing towards your functional goals, relieve pain, and increase movement ability. Through evaluation and individualized treatment programs, our physical therapists can both treat existing problems and provide preventive health care for people with a variety of needs. We are a friendly and multilingual staff consisting of physical therapists, massage therapists, and physical therapist aides. Our professional office staff is ready to assist you with any of your insurance or administrative questions.

Each individualized treatment program will consist of manual techniques, patient education, and therapeutic exercises designed to maximize the functional benefit of each patient.

You should notice changes in how your body is functioning or feeling during or after therapy. It is always recommended to give feedback to your therapist regarding any changes in your symptoms whether positive or negative in order to modify your treatments appropriately.

We suggest comfortable attire for physical therapy such as shorts, shirts, and tennis shoes. We kindly request that you not bring small children into the gym area for safety reasons. The gym equipment is for patient use only.

Please give a 24 hour cancellation notice before appointment time during business hours in order to avoid a $50.00 cancellation fee. Weekend and voicemail cancellation will be charged a $50.00 fee.

Thank you again for choosing Orthosport Physical Therapy.

Our office hours are:
M-F: 7:30 AM - 7:00 PM
Saturday and Sunday: Closed

Many of our patients appreciate our services so much that they recommend people to our facility. As a token of our appreciation, we offer a gift certificate for a 30-minute massage to those who refer people to our practice.

For your convenience, we have designated patient parking at our facility. If you have any questions, please do not hesitate to ask.