Orthosport Physical Therapy

10190 Culver Blvd. Culver City, CA 90232
Tel: (310) 837-9700 Fax: (310)837-9701
www.orthosportpt.net

Dear New Patient:

Welcome to Orthosport Physical Therapy!

- Thank you for choosing us as partners in your journey to restore motion and help you to function at your personal best! We promise to make your time here a valuable and enjoyable experience.
- In the current environment and for the foreseeable future, we will diligently follow all safety precautions related to COVID19, including the recommendations of The Center of Disease Control (CDC), American Physical Therapy Association (APTA), The Occupational Safety and Health Act (OSHA), as well as adhering to all local directives. Please check our website for details. (Click on COVID 19 link.) Our top priority is the protection of the health and wellness of our patients and staff.
- Our licensed-physical therapists utilize "a comprehensive whole body" approach, treating existing problems as well as providing preventive tips and a complete maintenance plan. Our licensed staff is multilingual and very friendly. Our professional office staff is here as well, and is ready to assist you with any of your insurance or administrative questions.
- Each individualized treatment will combine skilled hands-on physical therapy with extensive patient education, conditioning, and specific strengthening/stretching programs. Objective measurements will be utilized to document patient progress and outcomes. This comprehensive approach is designed to restore functional movement, relieve pain, and promote healing and recovery.
- Emphasis will be made on teaching *injury prevention* and *healthy behaviors* in order to maintain the improvements made as a result of your Orthosport Physical Therapy treatments. We want you to quickly be able to enjoy your work and the activities of daily living and to make it a way of life.
- You will be given videos (on cell phone or computer), with detailed instructions on home exercise regimens that best suit your personalized needs.
- You should notice changes in how your body is functioning or feeling during or after therapy. We recommend that you give feedback to your therapist regarding any changes in your symptoms, positive or negative, in order to modify your treatments appropriately.
- We suggest comfortable attire for physical therapy such as shorts, shirts, and tennis shoes.

Please give 1 business day 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.

For latest changes and best tips please follow us on
Facebook www.facebook.com/OrthosportPhysicalTherapy/
Instagram www.instagram.com/orthosport_physical_therapy/

The highest compliment we can receive is a referral or introduction to your friends and family!

Orthosport Physical Therapy

www.orthosportpt.net

PATIENT ASSUMPTION OF RISK AND WAIVER OF LIABILITY RELATING TO CORONAVIRUS/COVID-19

I, _____, (patient name) have been informed, understand and voluntarily assume the risk as to the following:

1. The novel coronavirus, COVID-19, is extremely contagious and is believed to spread mainly from person-to-person contact. The staff at the OPTC, Westside Inc dba Orthosport Physical Therapy are closely monitoring this developing situation and have put in place required preventative measures to reduce the spread of COVID-19. However, due to the nature of this virus, Orthosport Physical Therapy cannot guarantee that you will not become infected with COVID-19.

2. We at Orthosport Physical Therapy encourage social distancing on our premises and take every effort to plan for your safety as well as safety of our staff to minimize contact among our patients. Still, I may become exposed to or infected by COVID-19 at the Orthosport Physical Therapy as a result of actions, omissions, or negligence of myself and others, including, but not limited to patients or the still the unknown nature of exact pathogenesis of COVID-19.

3. Possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my treatment, I may need additional care that may require me to go to an emergency room or a hospital. During the treatment and recovery, I may be me more susceptible to infection. COVID-19 may cause additional risks, many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment itself.

In addition to the above acknowledgements, I promise to make reasonable efforts to prevent exposing other patients and staff of Orthosport Physical Therapy to infection by maintaining social distancing, wearing a mask and other personal protective equipment, whenever possible. I promise to undertake any additional reasonable precautions recommended by the CDC and any other relevant authorities.

_____ (Initial)

_____ (Initial) I confirm that I have not experienced any of the following symptoms of COVID-19 during the past 14 days:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat

_____ (Initial) I understand that avoiding direct contact and social distancing of at least 6 feet is not possible with my procedure.

_____ (Initial) I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.

_____ (Initial) I verify that I have not traveled by commercial airline, bus, or train within the past 14 days.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and the person accompanying me including, but not limited to, illness, liability of any kind, that I or the person accompanying me may experience or incur in connection with my attendance at the Orthosport Physical Therapy On my behalf, and on behalf of the person accompanying me, I hereby release, covenant not to sue, discharge, and hold harmless the Orthosport Physical Therapy, its employees, agents, and representatives, of and from the claims, including all liabilities, actions, damages, costs or expenses of any kind (together "Claims") arising out of or relating to my treatment. I understand and agree that this release includes any Claims based on the actions, omissions (excepting negligence or intentional torts) of the Orthosport Physical Therapy, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after attendance at facility.

_____ _____

Patient's Signature Today's Date

_____

Print Patient Name

Patient's Name: _____D.O.B._____Soc.Sec #_____
Last First M.I.

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

We like to give appointment reminders via text messages, can I set you up? Cell: _____

Please indicate your preferred social media of use: □ Facebook □ Instagram

Email Address_____

Emergency contact: _____Relationship_____ Phone _____

Referred by: _____Phone _____

Financial Responsibility Information:

Health Insurance _____ Medicare _____ Other_____

Please provide this office with copies of the following: Health Insurance Card, Driver's License, & MD PT Order

Have you had home healthcare or home therapy? YES NO

Name of Agency: _____ Last date seen: _____

Phone number: _____

When did your condition begin? Onset (day/month/year): _____ Other: _____

Injury type: □ Work □ Auto □ Other _____

Lawyer involved: YES NO Attorney name: _____

Past medical history:

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

_____

_____

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

_____

_____

3. 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:

Please initial all paragraphs that apply:

_____ Release of Medical Record(s): I have read and fully understand Orthosport Physical Therapy's Notice of Information Practices. I understand that Orthosport Physical Therapy 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 Orthosport Physical Therapy 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 Orthosport Physical Therapy'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.

_____ Consent for Care: Your therapists will discuss with you your diagnoses, treatments, risks, benefits and reasonable expectations for desired results. I am expected to ask any questions I may have regarding the information, so I will have an understanding of the information provided. I hereby give my consent to the staff of Orthosport Physical Therapy to provide therapy care and services prescribed by my physician, or by direct access, to exercise professional judgment regarding any additional care and services that may be necessary. I understand there are potential risks as well as benefits from physical therapy and I have been approved by my physician or under direct access to receive physical therapy.

_____ Appointment/ Compliance: Please kindly arrive on time. 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 1 business day notice.** I will be held responsible for the fee and my credit card will be charged. Monday cancellation should be done no later than Friday 12:00 PM in order to allow us to fill your appointment and not be charged.

_____ 3rd Party Lien/Legal: 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 will be responsible for my bill. I agree to pay reasonable attorney's fees and/or other such costs as the Court determines proper.

_____ Financial Agreement: I hereby instruct and direct my Insurance Company to pay by direct deposit or check made out and mailed directly to: OPTC Westside Inc dba Orthosport Physical Therapy, 10190 Culver Blvd, Culver City, Ca 90232

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.

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 Orthosport Physical Therapy for authorized services, I am financially responsible and will pay Orthosport Physical Therapy, on behalf of my insurance company, from whom I will seek reimbursement after canceling my debt with Orthosport Physical Therapy

_____ **Medicare:** I understand Medicare will not cover physical therapy if I'm 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, I will be held responsible for the visit.

_____**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. 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.

_____ _____

Patient Name Signature

_____

Date

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