

PATIENT FINANCIAL POLICY

Dear Valued Patient:

We would like to share the following policies with you so that you can understand your responsibility regarding charges for the services rendered to you by this office.

We participate with *most* commercial U.S. insurance plans. We will gladly bill your primary and secondary insurance carriers, as a courtesy, for services rendered. You will be responsible at the time of service for payment of:

- A. The annual deductible
- B. Co-payments or Co-insurance amounts for office visits
- C. Charges for non-covered services

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.

Most insurance plans have a **“co-insurance”** amount which you will be billed for once we receive the Explanation of Benefits from your insurance carrier for services rendered. Examples of “co-insurance” are as follows: If your insurance covers 90% of the contracted/allowed amounts, then you will have a 10% co-insurance; if your plan covers 60% of the contracted/allowed amounts, then you will have a 40% co-insurance. Our billing department will be glad to assist you if you have questions regarding co-insurance. However, since there are *multiple* insurance plans, it is advisable that you contact your Member Services Department with your insurance carrier to obtain this information.

Medicare:

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible (\$131 for the year 2007) and paying the 20% co-payment. We will file with secondary/supplemental carriers.

In the event that your insurance carrier fails to pay for services, you will be billed for the unpaid charges.

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

Patient/Responsible party signature

Date

PATIENT INFORMATION FORM

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

Home Address _____ Phone _____
Number & Street City/Town State Zip Area code & #

Patient's Employer _____ Phone _____
Name & Address Area code & #

Spouse's Name _____ D.O.B. _____ Sex _____ Soc.Sec.# _____
Last First M.I.

Email Address _____ Prefer no emails

Relative whom we can contact in event of emergency:

Name _____ Relationship _____
Last First M.I.

Address _____ Phone _____
Number & Street City/Town State Zip Area code & #

Referred by: () Dr. _____ Phone _____
Physician's Name & Address Area code & #

() Other _____ Phone _____
Name & Address Area code & #

Financial Responsibility Information:

Health Insurance _____ Worker's Comp. Insurance _____ Medicare _____ Other _____

Insurance Information: _____ Phone _____

Secondary Insurance _____ Phone _____

Subscriber's Name: _____ I.D. # _____ Group # _____
Medicare / Certificate #

Attorney Information: _____ Phone _____
Name & Address Area code & #

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

Explain in detail please: _____

Financial agreement and authorization for treatment:

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 of B.H. on behalf of my insurance company, from whom I will seek reimbursement after canceling my debt with Physical Therapy Specialists of B. H.

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.

Signature _____ Date _____

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

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

Cancellation Policy: You must arrive 10 minutes prior to you scheduled appointment to prepare for treatment. We request that you please give at least 24 hours notice if a cancellation is necessary to avoid a **\$50 charge**. In order for us to verify your appointment, please make sure to bring you schedule card to the appointment.

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

Or

If current policy prohibits direct payment to Physical Therapy Specialists, then I hereby also instruct and direct you to make out the check to me, the patient, as follows:

_____ (Patient's Name)

C/o 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.

Signature of Patient _____

Date of Signing _____



Physical Therapy Specialists
200 N. Robertson Blvd., Suite 301 Beverly Hills, CA 90211
Ph: 310-273-8256 Fax: 310-273-8542

PATIENT HISTORY

NAME: _____ SEX: _____ DATE OF BIRTH: _____

Please complete all requested information

1. Have you ever had? (If Yes, please explain)

High Blood Pressure	No	Yes	_____
Heart or Circulation Disorders	No	Yes	_____
Seizures	No	Yes	_____
Dizzy Spells	No	Yes	_____
Diabetes	No	Yes	_____
Cancer	No	Yes	_____
Arthritis/ Osteoarthritis	No	Yes	_____
Osteoporosis	No	Yes	_____
Immune deficiency Disease	No	Yes	_____
Other	No	Yes	_____

2. Please list surgeries you have had; please give procedures and dates, if possible:

3. Please list recent diagnostic studies (Cat-Scan, MRI, X-rays): _____

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

5. (For women only) Are you now pregnant? No Yes. Date of last menstrual cycle: _____

6. Do you have any abnormal trouble with vision? No Yes / Hearing? No Yes

7. List any allergies you may have: _____

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

9. Have you had an unusual weight gain or loss lately? No Yes

10. List medications you are now taking: _____

11. Have you ever had physical therapy treatments before? No Yes

If yes, please indicate where, when, and for what problem: _____

12. Describe briefly the history of your present **ACCIDENT, INJURY OR ILLNESS:**

Onset: _____ Description: _____

13. Date of next Doctor appointment: _____

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 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. 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 practice manager at Physical Therapy Specialists. You may also send a written complaint to the US Department of Health and Human Services.