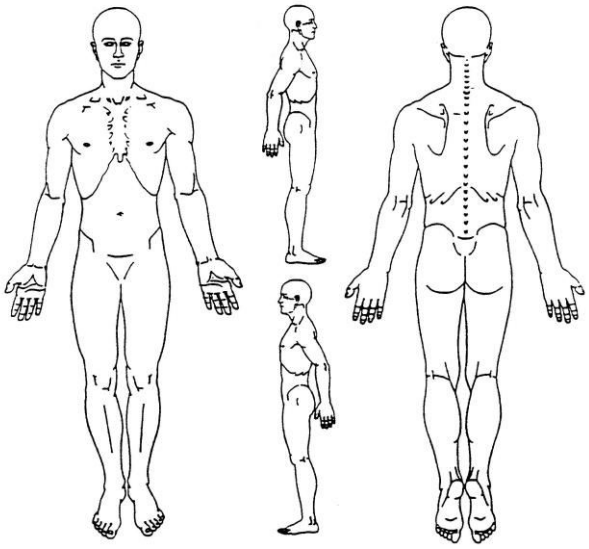
The Physical Therapy Effect

PATIENT INFORMATION

Please present your insurance card and driver's license for copying

Patient Name:	Sex:	Date of Birth:	Age:	Height:	Weight:
Employment Status: Emp Unemp Retired Student				Marital Status:	
Address:					
Home Phone:	Work Phone:	Employer:			
E-Mail Address:		Referring MD:			
How did you hear about us: (circle one)	Internet Friend Doctor Walk In Other_____				
Financial Party (if other than patient):	Relationship:	Social Security Number (Tricare Only):		Date of Birth:	
Home Phone:	Work Phone:	Employer:			
Emergency Contact:	Relationship:	Home Phone:			
Current Injury:		**Date of Onset:**			



Please give a brief description about your current injury (ie. What is bothering you?)

←Please shade in the areas of your symptoms.

What makes your condition worse?

What makes your condition better?

Are there any activities you currently are unable to do because of your condition?

Is your Condition getting better or worse?

Does your condition disturb your sleep?

What are your goals for Physical Therapy?

The Physical Therapy Effect

Medical Systems Review

Have you recently experienced any of the below?			
Abnormal sensations (eg, numbness, pins and needles)?	YES	NO	N/A
Headaches?	YES	NO	N/A
Night pain?	YES	NO	N/A
Night sweats?	YES	NO	N/A
Sustained morning stiffness?	YES	NO	N/A
Light-headedness?	YES	NO	N/A
Trauma (eg, a motor vehicle accident, a fall)?	YES	NO	N/A
Easy bruising?	YES	NO	N/A
Changes in vision?	YES	NO	N/A
Constipation?	YES	NO	N/A
Changes in menstruation patterns? (Females Only)	YES	NO	N/A
Gait or balance disturbances?	YES	NO	N/A
Pain with rest?	YES	NO	N/A
Shortness of breath?	YES	NO	N/A
Muscle weakness?	YES	NO	N/A
A failure of conservative intervention (failure to improve within 30 days)?	YES	NO	N/A
Excessive sweating?	YES	NO	N/A
Edema or weight gain?	YES	NO	N/A
A heartbeat in your abdomen when you lie down?	YES	NO	N/A
Cramps in your legs when you walk for several blocks?	YES	NO	N/A
Abdominal pain?	YES	NO	N/A
Changes in the integrity of your nails?	YES	NO	N/A
Prolonged use of corticosteroids?	YES	NO	N/A

Do you suffer from?		
High Blood Pressure	YES	NO
Heart Attack/ Disease	YES	NO
Pacemaker	YES	NO
Diabetes	YES	NO
Kidney Problems	YES	NO
Stroke	YES	NO
Seizures	YES	NO
Cancer	YES	NO
Fever	YES	NO
Osteoporosis	YES	NO
Pregnancy (current/past)	YES	NO

Please list current medications and allergies & Past Medical History:

The above information is correct to the best of my knowledge. In signing below, I agree to be treated by the staff of The Physical Therapy Effect. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by The Physical Therapy Effect. I authorize payment of medical benefits directly to The Physical Therapy Effect. I understand that I am financially responsible to The Physical Therapy Effect for all unpaid balances.

Signed: _____ Date: _____

The Physical Therapy Effect

Office Payment Policy

It is the policy of The Physical Therapy Effect, P.C. that payment is due and to be made at the time of service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 30, 45 or 60 minutes long. Charges range from $25 to $40 per 15-minute increments, depending upon the type of treatment being performed.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manger before starting your treatments. Failure to provide all pertinent insurance information absolves us of **responsibility for billing primary, secondary, etc insurance.**

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____ **1. PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a copay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and copays are due at the time of service. We will bill you for coinsurance or other payment due after we have been paid by your insurance or notified of their denial for payment.

_____ **2. HMO Insurance:** Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

_____ **3. MEDICARE:** The Physical Therapy Effect, P.C. is a certified Medicare provider. Medicare has an annual deductible of $166.00 and an annual benefit limit of $1960.00 for PT and Speech. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

_____ **4. NO INSURANCE:** If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____ **5. OTHER:** Please list the other insurance:_____ If none please initial here: _____

_____ **6. WORKER'S COMPENSATION CLAIMS**: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

_____ **7. THIRD PARTY PAYERS AND AUTO LIENS**: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. You are responsible for payment of all service provided. Please be sure to contact this office when your case is settled to ensure your account has been paid.

ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS:
Please sign a release of information authorizing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid.

I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____*CMM Rev. 4/2006*

(Failure to sign this form absolves The Physical Therapy Effect, P.C. of responsibility of billing patients insurance, if pertinent.)

The Physical Therapy Effect

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PHYSICAL THERAPY EFFECT'S LEGAL DUTY

The Physical Therapy Effect 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 DISCLOSURE OF HEALTH INFORMATION

The Physical Therapy Effect 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, we 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.

The Physical Therapy Effect 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.

The Physical Therapy Effect 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 you 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. The Physical Therapy Effect 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 we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of you personal health information please contact our Privacy Officer 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 our health information practices or if you have a complaint please contact the following person:

The Physical Therapy Effect
Attn: Mark Shulman
1601 Kettner, Suite 11
San Diego, CA 92101

Effective: March 2013

PATIENT INFORMATION CONSENT FORM

I have read and fully understand The Physical Therapy Effect's Notice of Information Practices. I understand that The Physical Therapy Effect 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 The Physical Therapy Effect 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 The Physical Therapy Effect'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