

FUNCTIONAL PHYSICAL THERAPY, INC. PATIENT INFORMATION

Date of First Visit _____ Date of Injury/Onset/Surgery: _____

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S M D W DL#: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Type of Accident: Auto Work Other Date of Accident: _____

Home Phone #: _____ Work Phone #: _____

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

If this is for a work related injury ask the following:

Does your employer have an MPN? Yes No

If yes, are we members of the MPN? Yes No

If we are not on the MPN whom do we call to get on the MPN? _____

Referring Physician: _____ Phone #: _____

Date of last MD Visit: _____ Diagnosis: _____

Prescription Frequency & Duration: _____

Referring Attorney: _____ Phone #: _____

Attorney Address: _____

City, State, Zip: _____

In case of emergency: _____ Phone #: _____

Have you had PT, OT, Speech, Chiro, Accupuncture this year? _____ How many visits? _____

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #: _____

Insured Date of Birth: _____ Group #: _____ Policy #: _____

Adjustor Name: _____ Phone #: _____

Claim #: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #: _____

Insured Date of Birth: _____ Group #: _____ Policy #: _____

Information taken by: _____ Date: _____

Functional Physical Therapy, Inc.
2245 E. Colorado Blvd #202
Pasadena, CA 91107
(626) 449-9910 Fax (626) 449-9382
Tax ID 32-0026193

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Functional Physical Therapy, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Functional Physical Therapy, Inc. to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Functional Physical Therapy, Inc., and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

Functional Physical Therapy, Inc.
2245 E. Colorado Blvd #202
Pasadena, CA 91107

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of \$50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Patient or Guardian Signature

Date

Functional Physical Therapy

PATIENT INFORMATION ACKNOWLEDGMENT FORM

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

Patient Name

Signature

Date

I also authorize Functional Physical Therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date

FUNCTIONAL PHYSICAL THERAPY

Information Release Authorization

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

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

For the following purpose:

This release authorization includes my personal health information consisting of:

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of Functional Physical Therapy having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Patient Name

Signature

Date

Functional Physical Therapy

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you (**Estimated Cost:** \$ _____)

Medicare will not pay for: PT & SPEECH LANGUAGE PATHOLOGY SERVICES OVER \$1740 PER YEAR

1. Because it does not meet the definition of any Medicare benefit

2. Because of the following exclusion * from Medicare benefits:

- | | |
|--|---|
| <input type="checkbox"/> Personal comfort items | <input type="checkbox"/> Routine physicals and most tests for screening |
| <input type="checkbox"/> Most shots (vaccinations) | <input type="checkbox"/> Routine eye care, eyeglasses and examinations |
| <input type="checkbox"/> Hearing aids and hearing examinations | <input type="checkbox"/> Cosmetic surgery |
| <input type="checkbox"/> Most outpatient prescription drugs | <input type="checkbox"/> Dental care and dentures (in most cases) |
| <input type="checkbox"/> Orthopedic shoes and foot supports (orthotics) | <input type="checkbox"/> Routine foot care and flat foot care |
| <input type="checkbox"/> Health care received outside of the USA | <input type="checkbox"/> Services by immediate relatives |
| <input type="checkbox"/> Services required as a result of war | <input type="checkbox"/> Services under a physician's private contract |
| <input type="checkbox"/> Services paid for by a governmental entity that is not Medicare | |
| <input type="checkbox"/> Services for which the patient has no legal obligation to pay | |
| <input type="checkbox"/> Home health services furnished under a plan of care, if the agency does not submit the claim | |
| <input type="checkbox"/> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997 | |
| <input type="checkbox"/> Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need). | |
| <input type="checkbox"/> Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital | |
| <input type="checkbox"/> Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF | |
| <input type="checkbox"/> Services of an assistant at surgery without prior approval from the peer review organization | |
| <input type="checkbox"/> Outpatient occupational and physical therapy services furnished incident to a physician's services | |

* **This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Patient Name: _____

Patient Signature: _____

Date: _____