

Physicians Choice Physical Therapy Patient History

Name: _____ Sex: M ___ F ___ Birthday: _____ Date: _____

<u>Have you ever had or currently have:</u>	<u>If yes, please explain:</u>	<u>Family History?</u>
High Blood Pressure:	Yes___ No___ _____	Yes___ No___
Heart Problems:	Yes___ No___ _____	Yes___ No___
Seizures:	Yes___ No___ _____	Yes___ No___
Dizzy Spells:	Yes___ No___ _____	Yes___ No___
Diabetes:	Yes___ No___ _____	Yes___ No___
Cancer:	Yes___ No___ _____	Yes___ No___
Arthritis	Yes___ No___ _____	Yes___ No___
Osteoporosis:	Yes___ No___ _____	Yes___ No___
Immune Deficiency:	Yes___ No___ _____	Yes___ No___
Depression:	Yes___ No___ _____	Yes___ No___
Incontinence:	Yes___ No___ _____	Yes___ No___
Abnormal Vision:	Yes___ No___ _____	Yes___ No___
Abnormal Hearing:	Yes___ No___ _____	Yes___ No___
Angina or Chest Pain:	Yes___ No___ _____	Yes___ No___
Shortness of breath:	Yes___ No___ _____	Yes___ No___
Urinary Tract Infect:	Yes___ No___ _____	Yes___ No___
Metal Implant in body:	Yes___ No___ _____	Yes___ No___
Allergies:	Yes___ No___ _____	Yes___ No___
Weight gain /loss:	Yes___ No___ _____	Yes___ No___
Other:	Yes___ No___ _____	Yes___ No___

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

Please list any accidents or injuries you have had: _____

Please list recent diagnostic studies (i.e. CAT Scan, MRI, X-rays): _____

Other problems that have been diagnosed by a physician? Yes___ No___

Please list all medications you are now taking: _____

(For women only) Are you pregnant now? Yes___ No___ Date of last menstrual cycle: _____

Have you ever taken steroids or anti-coagulants for an extended period of time? Yes___ No___

Have you ever had physical therapy treatments before? Yes___ No___

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

What are your goals in Physical Therapy? _____

Physicians Choice Physical Therapy

PATIENT INFORMATION ACKNOWLEDGMENT FORM

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

PHYSICIANS CHOICE PHYSICAL THERAPY

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Physicians Choice Physical Therapy 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 Physicians Choice Physical Therapy 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 Physicians Choice Physical Therapy, 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:

Physicians Choice Physical Therapy
12113 Santa Monica Blvd #203
West Los Angeles, CA 90025

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

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: _____