Patient Information Sheet

DEMOGRAPHICS

Last Name: _____First Name:_____ MI:_____ Gender:_____

Birthdate:_____ Age:_____ SSN:_____ Marital Status:_____

Home Address:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____ ☐ Check this box if you would prefer to not receive emails.

Emergency Contact Name: _____ Phone Number:_____

Name of Employer: _____ Occupation: _____

ONSET OF INJURY

Referring Physician:_____ Next scheduled appt.:_____

Date of Injury: _____ Is this injury **work related**? YES or NO (If yes, we cannot bill without prior auth)

Have you had any Physical Therapy or Speech Therapy this year? _____ If so, number of visits: _____

Have you had any Chiropractic treatments this year? _____ If so, number of visits: _____

Medicare Patients- Have you had any type of **Home Health Care** recently? _____ (Medicare will not pay for Home Health and our services at the same time.) Have you been declared disabled by the State? _____

RELEASE OF INFORMATION

Medical information will be released only to physicians, hospitals, attorneys, medically affiliated agencies, insurance companies, and their agents. Your signature below gives us your permission to release information requested by any of the above described classes of persons. Medical information includes claims data which relate to the medical conditions and/or treatment of the patient. Evaluation and Progress reports will be sent to referring physicians. Your signature gives authorization for direct payment of medical benefits to Professional Physical Therapy Associates, Inc.

Patient Signature: _____ Date: _____

MISSED APPOINTMENT POLICY AND APPOINTMENT REMINDER CONSENT FORM

As a courtesy to our patients, we provide appointment reminders via text, voicemail, or email. Please choose one of the following convenient tools as a reminder.

If you prefer not to receive a reminder, please do not chose one of the following reminder options. We will update your file.

Select one option below:

- **TEXT REMINDER**

  I authorize PPT to send text message reminders to confirm upcoming appointments.

  My cell phone number is :_____

- **VOICEMAIL REMINDER**

  I authorize PPT to send voicemail reminders to confirm upcoming appointments.

  My phone number is :_____

- **EMAIL**

  I authorize PPT to send email reminders to confirm upcoming appointments/feedback/ health information.

  My email address is:_____

I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information, unless changed in writing.

A **24 hour notice** is required for an appointment to be rescheduled. We understand emergencies may arise. Please extend us a courtesy call to cancel appointments. We reserve the right to charge a **$50** failed appointment fee.

Print Name:_____ Date:_____

Signature:_____ Date:_____

CONSENT OF TREATMENT AND THERAPEUTIC PROCEDURES

I consent to treatment and therapeutic procedures to be performed by Professional Physical Therapy Inc., and it's associates. _____ (please initial)

- I agree have an evaluation performed and receive treatment for functional losses due to related skeletal and muscle dysfunctions, nerve damage, and/or pain.
- I understand that the purpose of treatment and procedures will be explained to me and I can refuse therapeutic procedures at anytime.
- I understand that I can seek treatment and recommendations from my medical team regarding my condition.
- I understand that therapeutic procedures can include, but are not limited to the following: joint and soft tissue mobilization, functional mechanics training, traction, modalities: taping, ultrasound, neuromuscular electrical stimulation, bladder training, and, BFR.

I certify that I have read and agree to the above statements:

Patient signature: _____ Date:_____

RELEASE OF LIABILITY

I agree that all exercises and use of the facility are undertaken at my sole risk and that Professional Physical Therapy and it associates shall not be liable for any claims for injuries or damages whatsoever to person or property of myself arising out of or connected with the use of the facility. I agree to indemnify and to hold the facility (Professional Physical Therapy, Associates, Inc.) and it's employees harmless from all claims by or liability.

The Novel Coronavirus/COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to be spread by person-to-person contact. As a result, Federal, State, and local governments and Federal and State health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed or infected by COVID-19 while receiving health care. I voluntarily agree to assume the risk and accept sole responsibility if the contraction of COVID-19 has any connection to Professional Physical Therapy Associates, Inc.

I certify that I have read and agree to the above statements:

Patient signature: _____ Date:_____

OFFICE POLICY REGARDING INSURANCE AND PAYMENT

PPT will verify your insurance coverage as a courtesy. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. Please provide our office with all insurance information including co-insurance, if available.
2. We will bill your insurance weekly as long as you are receiving care in this office.
3. You are required to pay the percentage or your responsibility or your copayment each visit. Copays and co-insurance will be collected prior to treatment and are due at the time of service.
4. If there is any balance due after your insurance has been billed, you will be responsible for that balance.
5. We do not bill insurance for supplies. You can purchase supplies on a cash basis.
6. Our office does not guarantee that your insurance company will pay. We will make every attempt at the beginning of your health care to receive verification of your primary policy and what it covers. However, if for some reason insurance claims are denied, you are responsible for payment in full.
7. You are responsible for bringing a prescription from your referring physician so that we may bill your insurance company. Insurance companies require a new prescription and or plan of care at the end of each prescription or plan of care.
8. Notify the front desk of address, phone number, doctor, insurance company changes.
9. We do accept Medicare. If you are receiving any type of home health care, Medicare will not pay for home health and our services at the same time. Home health must be discharged prior to treatment at our facility.
10. If your account is turned over to collections, you will be responsible for attorney and collection fees.
11. You will receive a statement if there is a balance on your account for any reason.
12. We do not accept workers comp without prior authorization from the adjuster/employer.
13. We do not bill most auto insurances. You can pay on a cash basis and seek reimbursement.
14. Your treatment will include exercises done in the gym immediately after or before your treatment. You may not leave and return at another time.

I understand financial responsibility and agree to be bound by the terms of this office policy.

Date:_____ Patient/Responsible Party signature: _____

RELEASE OF INFORMAITON AND AUTHORIZATION TO PAY BENEFITS

I authorize Professional Physical Therapy Associated, Inc. to release any of my information required to process medical claims and I also give authorization for direct payment of medical benefits to Professional Physical Therapy Associate, Inc. I clearly understand that I am responsible for my account directly to Professional Physical therapy regardless of the status of my insurance company.

Date:_____ Patient/Responsible Party signature: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)
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.

Professional Physical Therapy Associates, Inc., LEGAL DUTY

PPT is required by law to protect the privacy of your health information, provide this notice about our information practices and follow the information practices that are described herein.

PPT uses your personal health information primarily for treatment; obtaining payment for treatment; obtaining insurance benefits for authorization for treatment conducting internal administrative activities and evaluation of the quality of care we provide.

PPT may also use or disclose your personal health information without prior authorization for public health purposes for emergencies or when required by law.

In any other situation, PPT's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PPT may change its policy at any time. When changes are made, a new Notice of Patient 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 and 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 (PHI) at any time. PHI includes your name, address, city, country, zip code, date of birth, date of service, telephone, fax or cell number, SSN, and account number. 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 any reason other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law in emergency circumstances. PPT 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 PPT 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 the U.S. Department of Health and Human Services. For further information of PPT's health information practices, or if you have a complaint, please contact the following person.

Annette Alvarez, Office Manager (562) 945-1587

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT INFORMATION PRACTICES

I have read and fully understand Professional Physical Therapy Associates, Inc. (PPT) Notice of Patient Information Practices. I understand that PPT 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 information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that PPT will consider requests for restriction on a case by case basis but does not have to agree to the request for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in PPT 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: _____