

PATIENT INFORMATION

→ _____ / ____ / ____
 ↑ Last Name, First Name, Middle Initial Date Of Birth

 Mailing Address City Zip Code (____) Home Phone

 E-Mail Address FEMALE MALE Circle One S M W D Marital Status

 Employer Employer Address City Zip Employer Phone

 Social Security Number Medicare Number

 How Did You Hear About Us? First & Last Name of Referring Physician Area Of Pain

 Emergency Contact Relationship Phone

GROUP HEALTH INSURANCE INFORMATION

 Primary Insurance Member ID # Group #

 Name Of Insured Relationship Insured's Date of Birth

 Secondary Insurance Name Of Insured & Date of Birth Member ID #

ACCIDENT INFORMATION

Is this visit the result of an injury? YES NO If so, date of injury: _____

Were you injured: _____ On The Job? _____ Auto Accident _____ Other?

(Please Explain) _____

Do you have prior authorization for pt benefits? YES NO Claim # _____

 Responsible Insurance Company Address City State Zip Name Of Adjuster

 Name Of Attorney Address Phone

I _____, hereby assign all medical benefits to include for services provided, including Medicare & other government sponsored programs, private insurance & any other health plans to _____. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize _____ to release all information necessary to secure the payment of said benefits. I understand that this assignment of benefits is irrevocable unless advised by me in advance. If any portion of therapy is denied I give _____ permission to act as my representative in appealing.
CONSENT TO TREAT: I hereby consent to receive treatment from the Outpatient Clinic consistent with a Plan of Care authorized by my physician.

X _____
 ↑ SIGNATURE DATE

FOR OFFICE USE ONLY

ACCOUNT # CLINIC/HOME THERAPIST ONSET SOC

TREATMENT DIAGNOSIS: _____

MD NPI # _____ KX ALL _____ Pt. Info. Revised 10.08

MEDICAL HISTORY AND PHYSICAL CONDITION INFORMATION

Patient Name: _____

Chief Complaint / Area of Pain: _____

Have you had treatment for this problem before? Yes No
If yes, where: _____ When? _____

If you are a Medicare patient, have you recently had care from a Home Health Agency? ____
If so, please provide the following information:
Name of Health Care Provider: _____
Name of Agency: _____ Phone: _____
Address: _____
Date of Discharge from Home Health Agency: _____

Have you had surgery related to this problem? Yes No
Surgical procedure: _____ Date of Surgery: ___/___/___

List medications you are taking that could affect your ability to perform Physical Therapy:
1. _____ 2. _____
3. _____ 4. _____

Do you have a pacemaker? Yes No
Do you have any communicable diseases? Yes No
Do you have any metal implants? Hip (R/L) Knee (R/L) Shoulder (R/L)
 Back Other _____

Circle any condition you currently have or have had in the past:

- | | | |
|-----------------------|--------------------------|----------------------|
| Allergies | Arthritis | Balance Difficulties |
| Cancer | Cardiac Arrhythmia | Circulatory Problems |
| Cognitive Impairments | Congestive Heart Failure | Diabetes |
| Dizzy Spells | Headaches | Hearing Problems |
| Heart Attack | Hernia | High Blood Pressure |
| HIV/AIDS | Kidney Disease | Pregnancy |
| Seizures | Vision Problems | |

Please explain: _____

The above information is correct, complete and to the best of my knowledge.

X _____
Signature

Date

FINANCIAL RESPONSIBILITIES

As a courtesy for our patients, the following insurance benefits have been verified by our Office Manager:

Date of eligibility: _____

Your deductible amount is _____ and has / has not been met.

Your insurance company will pay _____.

You are responsible for _____.

Your insurance company allows _____ visits per year.

***Minimum co-pay is \$10 per visit, due at time of treatment. Any outstanding balance will be billed to you.**

Note any special circumstances:

I understand that it is my responsibility to confirm my Physical Therapy benefits with my insurance company. The above information has been verified by this office, however, it is ultimately the insurance company who determines what they will allow for payment. Services ordered by your physician, but determined to be "not medically necessary" are the responsibility of the patient. If you have any questions, our Office Manager will be glad to assist you.

CANCELLATION POLICY

Canceling your appointment in advance allows us to schedule other patients and assists in staffing our qualified therapists. We require a 12 hour cancellation notice before your scheduled appointment to avoid a **\$15.00 charge**. (No exceptions). **"No show" charge is \$25.00.**

*I understand that I will be charged **\$15.00 for any cancellation** with less than 12 hour notice and **\$25.00 for any "No Show"** to my Physical Therapy appointments. I will be responsible for payment prior to my next scheduled treatment.*

Patient Name

Date

Patient Signature

Office Manager

INFORMATION RELEASE AUTHORIZATION

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

Name: _____ to: Name: _____
Address: _____
City/State: _____
Zip Code: _____

For the following purposes:

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 Corona del Mar Rehab having received this 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 INFORMATION CONSENT / HIPAA NOTIFICATION

*I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Corona del Mar Rehab's Notice of Information Practices**. (Posted on premises and on reverse) I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

I do not wish that my personal health information be released for reasons other than treatment or billing.

Patient Signature: _____ Date: _____