



Physical Therapy Specialists  
200 N. Robertson Blvd., Suite 301 Beverly Hills, CA 90211  
Ph: 310-273-8256 Fax: 310-273-8542

### PATIENT HISTORY

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**Please complete all requested information**

1. Have you ever had? (If Yes, please explain)

High Blood Pressure	No	Yes	_____
Heart or Circulation Disorders	No	Yes	_____
Seizures	No	Yes	_____
Dizzy Spells	No	Yes	_____
Diabetes	No	Yes	_____
Cancer	No	Yes	_____
Arthritis/ Osteoarthritis	No	Yes	_____
Osteoporosis	No	Yes	_____
Immune deficiency Disease	No	Yes	_____
Other	No	Yes	_____

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

\_\_\_\_\_  
\_\_\_\_\_

3. Please list recent diagnostic studies (Cat-Scan, MRI, X-rays): \_\_\_\_\_  
\_\_\_\_\_

4. Do you have any metal anywhere in your body; pins/ plates post fracture, or pacemaker (other than teeth)? No Yes, Describe: \_\_\_\_\_

5. (For women only) Are you now pregnant? No Yes. Date of last menstrual cycle: \_\_\_\_\_

6. Do you have any abnormal trouble with vision? No Yes / Hearing? No Yes

7. List any allergies you may have: \_\_\_\_\_

8. Have you ever taken steroids or anti-coagulants for an extended period of time? No Yes

9. Have you had an unusual weight gain or loss lately? No Yes

10. List medications you are now taking: \_\_\_\_\_  
\_\_\_\_\_

11. Have you ever had physical therapy treatments before? No Yes  
If yes, please indicate where, when, and for what problem: \_\_\_\_\_  
\_\_\_\_\_

12. Describe briefly the history of your present **ACCIDENT, INJURY OR ILLNESS:**  
Onset: \_\_\_\_\_ Description: \_\_\_\_\_  
\_\_\_\_\_

13. Date of next Doctor appointment: \_\_\_\_\_

# PATIENT INFORMATION FORM

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_  
Last First M.I.

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Number & Street City/Town State Zip Area code & #

Patient's Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Name & Address Area code & #

Spouse's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_  
Last First M.I.

Email Address \_\_\_\_\_  Prefer no emails

## Relative whom we can contact in event of emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Number & Street City/Town State Zip Area code & #

Referred by: ( ) Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Physician's Name & Address Area code & #

( ) Other \_\_\_\_\_ Phone \_\_\_\_\_  
Name & Address Area code & #

## Financial Responsibility Information:

Health Insurance \_\_\_\_\_ Worker's Comp. Insurance \_\_\_\_\_ Medicare \_\_\_\_\_ Other \_\_\_\_\_

Insurance Information: \_\_\_\_\_ Phone \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Medicare / Certificate #

Attorney Information: \_\_\_\_\_ Phone \_\_\_\_\_  
Name & Address Area code & #

**Injury Information:** Is your injury related to work?( ) an auto accident?( ) personal injury?( )

Explain in detail please: \_\_\_\_\_

## Financial agreement and authorization for treatment:

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I have Insurance coverage, I authorize my insurance company named above to process and pay all claims for services rendered. I understand that if for any reason my insurance company does not pay Physical Therapy Specialists for authorized services, I am financially responsible and will pay Physical Therapy Specialists of B.H. on behalf of my insurance company, from whom I will seek reimbursement after canceling my debt with Physical Therapy Specialists of B. H.

If treatment received is for a personal injury where a third party insurance or attorney is involved, I agree to sign a lien against any settlement received by me and/or my attorney. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me, I/we agree to pay reasonable attorney's fees and/or other such costs as the Court determines proper.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please provide this office with copies of the following cards: Health Insurance Card, and your Drivers License

## **PATIENT FINANCIAL POLICY**

Dear Valued Patient:

We would like to share the following policies with you so that you can understand your responsibility regarding charges for the services rendered to you by this office.

We participate with *most* commercial U.S. insurance plans. **We are out of network with the following plans: United Healthcare, Oxford, Pacificare, Benesight, Healthcare LA, Global Care, Bella Vista, Mission Community, Watts Healthcare, and El Protecto Del Barrio.** You will be responsible at the time of service for payment of:

- A. The annual deductible
- B. Co-payments or Co-insurance amounts for office visits
- C. Charges for non-covered services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

As a courtesy, we will verify your benefits with your insurance company. We are sometimes quoted incorrect benefits, therefore, it is the **patients** responsibility to know the plan benefits and should we be misquoted, you will be billed for the proper amount.

Most plans have a limit on the number of visits for physical therapy. It is the **patients** responsibility to know that number and to make sure that it is not exceeded. Should you go over the limit, you will be billed for the visit.

Should your account end up in our collections department for any reason, you will incur a \$10.00 fee.

Should you have any questions, our billing department would be happy to assist you.

### **Medicare:**

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible (\$162 for the year 2011) and paying the 20% co-payment. We will file with secondary/supplemental carriers. In the event that your insurance carrier fails to pay for services, you will be billed for the unpaid charges.

**Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.**

\_\_\_\_\_  
Patient/Responsible party signature

\_\_\_\_\_  
Date

**Physical Therapy Specialists**  
**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. PLEASE REVIEW IT CAREFULLY.

**Physical Therapy Specialists LEGAL DUTY**

Physical Therapy Specialists 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 DISCLOSURES OF HEALTH INFORMATION**

Physical Therapy Specialists 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, Physical Therapy Specialists 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.

Physical Therapy Specialists may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physical Therapy Specialists 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.

Physical Therapy Specialists 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 your 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. Physical Therapy Specialists 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 Physical Therapy Specialists 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 Physical Therapy Specialists. You may also send a written complaint to the US Department of Health and Human Services.

**PATIENT INFORMATION CONSENT FORM**

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

**Cancellation Policy:** You must arrive 10 minutes prior to you scheduled appointment to prepare for treatment. We request that you please give at least 24 hours notice if a cancellation is necessary to avoid a **\$50 charge**. In order for us to verify your appointment, please make sure to bring you schedule card to the appointment.

**Financial Agreement:** I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

Physical Therapy Specialists, Inc.  
200 N. Robertson Boulevard, Suite 301  
Beverly Hills, CA 90211

Or

If current policy prohibits direct payment to Physical Therapy Specialists, then I hereby also instruct and direct you to make out the check to me, the patient, as follows:

\_\_\_\_\_  
(Patient's Name)

C/o Physical Therapy Specialists, Inc.  
200 N. Robertson Boulevard, Suite 301  
Beverly Hills, CA 90211

The professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient \_\_\_\_\_

Date of Signing \_\_\_\_\_