SANTA ANA TUSTIN PT NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:_____

Name (First)_____(Last)_____ (M.I.) _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Other Phone_____

Social Security_____ Birth Date_____ Age _____Sex: M / F

Drivers Lic #_____ Email Address_____

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Emergency Contact_____ Telephone_____

Referring Physician_____ Telephone _____

Referring Dr. Address _____ UPIN # _____

Who may we thank for your referral other than your Doctor?_____

Employer_____ **Employment** Full / Part-time / Not Working / Retired

Address_____Phone_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____Injury Date _____

Lawyer Involved Yes / No Attorney name _____

Address_____ Telephone # _____

We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. In addition, you understand that SATPT requires 24-hours notice in the event of a cancellation, and that you may be charged $40. for cancellation without proper notice; this charge will not be covered by insurance.

Patient Signature:_____ **Date:**_____

(OFFICE USE ONLY) 113005

Financial Class: **PTPN** ☐ Yes ☐ No **(please check one)**

☐ Comm'l Insurance (select one): __Aetna __BlueCross __BlueShield __Cigna __Healthnet __United Health __Other

☐ Workers' Comp

☐ Gov't (select one): __US Dept of Labor (OWCP) __Medicare __Medicaid

☐ Other (select one): __Auto __CAP __IPA __Lien __Program:_____

Therapist: **Davis** **Patel** **Lee** **Danforth** **Sorrentino**

11/29/2007

SANTA ANA TUSTIN PT — OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Santa Ana Tustin Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature _____ **Date**_____

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Santa Ana Tustin Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Santa Ana Tustin Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $40 for physical therapy visits and the full price of a massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $_____

Arrangements for payment of patient's co-pay/deductible **(circle one):**

Will pay each visit **Will pay weekly in advance**

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party **Date**

Clinic Representative **Date** 051005

SANTA ANA TUSTIN P[illegible] MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____ Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

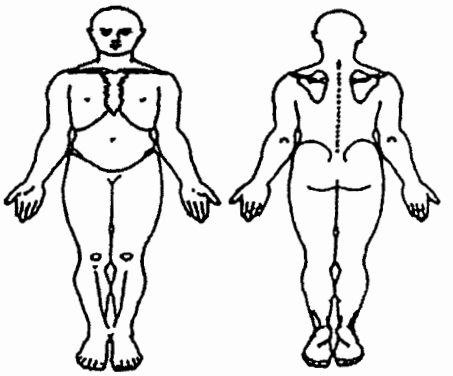
Describe previous treatment for this condition _____

_____

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Please mark the area(s) of concern

Have you had any imaging performed:

- X-Ray
- MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted:

- Weight Loss /Gain
- Weakness
- Pregnant / IUD
- Pain At Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps In Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision Or Hearing
- ☐ Insomnia

Do you have now or have you ever had any of the following?

- Surgeries
- Sprains / Strains
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity

Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above _____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

_____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals: _____

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

_____ _____

Patient or Personal Representative Signature **Date**

1/9/2007

Santa Ana Tustin Physical Therapy Inc

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.

Santa Ana Tustin Physical Therapy Inc's LEGAL DUTY

Santa Ana Tustin Physical Therapy Inc 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

Santa Ana Tustin Physical Therapy Inc 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, Santa Ana Tustin Physical Therapy Inc 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.

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

In any other situation, Santa Ana Tustin Physical Therapy Inc's 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.

Santa Ana Tustin Physical Therapy Inc 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 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. Santa Ana Tustin Physical Therapy Inc 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 Santa Ana Tustin Physical Therapy Inc 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 to the US Department of Health and Human Services. For further information on Santa Ana Tustin Physical Therapy Inc's health information practices or if you have a complaint, please contact the following person:

Antone L. Davis II, Office Administrator

1910 Old Tustin Ave.
Santa Ana, CA 92705

Telephone: (714)835-6638 **Fax: (714)835-4889**

Santa Ana Tustin Physical Therapy Inc
PATIENT INFORMATION
Acknowledgement Form

I have read and fully understand Santa Ana Tustin Physical Therapy Inc's Notice of Information Practices. I understand that Santa Ana Tustin Physical Therapy Inc 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 Santa Ana Tustin Physical Therapy Inc 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 Santa Ana Tustin Physical Therapy Inc'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