



# PATIENT INFORMATION

Today's Date \_\_\_\_\_  
Patient Acct. # \_\_\_\_\_

Welcome! We appreciate your help in providing this information to complete your medical record

Account Type \_\_\_\_\_  
Therapist \_\_\_\_\_

Have you ever seen one of our therapists before? Yes  No

Date you return to your Dr. \_\_\_\_\_

1. Your Name \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Home Street Address \_\_\_\_\_ Apt# \_\_\_\_\_

Driver's License# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security# \_\_\_\_\_

Phone \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_

Other I.D.# \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

In case of emergency, please notify: Relationship: \_\_\_\_\_

Female  Male  Single  Married

Name \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

2. Spouse/Parent Info (circle one) \_\_\_\_\_

5. Identity Theft Security Question (used to help identify you on phone):  
\_\_\_\_\_ ?

Address \_\_\_\_\_ Apt# \_\_\_\_\_

Answer: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Driver's License# \_\_\_\_\_

6. Date Injured or Symptoms Started \_\_\_\_\_

3. Person responsible for payment (check one):  Self  Spouse

Your Occupation \_\_\_\_\_

Father  Mother Other \_\_\_\_\_

Is your injury or illness: Employment related?  Yes  No

Payor Name \_\_\_\_\_

Accident related?  Yes  No

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

7. Do you have another physician following your care that you would like us to send reports to?  Yes  No

Address \_\_\_\_\_ Apt# \_\_\_\_\_

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How were you referred to us?  Doctor  Friend  Phonebook

Phone \_\_\_\_\_

Sign  Insurance  Internet

Home \_\_\_\_\_ Work \_\_\_\_\_

Other \_\_\_\_\_

4. Employer's Name \_\_\_\_\_

How did you find our phone number/address?  Doctor  Friend

Street Address \_\_\_\_\_

Phonebook  Internet  Car's GPS  Sign  Called

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Map on referral form  Other \_\_\_\_\_

8. Insurance Information: Who may assist you with payment of fees?

Worker's Compensation  Private insurance  Automobile insurance  Medicare  No insurance

Other \_\_\_\_\_ Does your insurance require prior authorization?  Yes  No

9. Primary Insurance \_\_\_\_\_

Adjuster name \_\_\_\_\_

Insured name \_\_\_\_\_

Group # \_\_\_\_\_

Address \_\_\_\_\_

Insured ID# \_\_\_\_\_

APT# \_\_\_\_\_

Medicare ID# \_\_\_\_\_

CITY \_\_\_\_\_ STATE ZIP \_\_\_\_\_

Relationship to insured \_\_\_\_\_

10. Worker's Compensation Additional Information:

Does your employer consider this a work injury?  Yes  No

Employer address \_\_\_\_\_

Doctor's name who first examined you \_\_\_\_\_

CITY \_\_\_\_\_ STATE ZIP \_\_\_\_\_

Name of employer at time of injury \_\_\_\_\_

Phone \_\_\_\_\_

11. I attest that the above stated is correct and true.

Date \_\_\_\_\_ Patient/Guardian Signature \_\_\_\_\_



## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><input type="checkbox"/> O.K. to fax to this number _____<br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> E-mail Address _____<br><input type="checkbox"/> Other _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

_____	_____
Patient Signature	Date
_____	_____
Print Name	Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Note: Uses and disclosures for treatment, payment and/or for our healthcare operations may be permitted without your specific prior authorization.**

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized  
 (2) Type key: T = Treatment Records P = Payment Information O = Healthcare Operations A = Authorization on File D = Discretionary  
 (3) Enter how disclosure was made: F = Fax P = Phone E = Email M = Mail O = Other



We are dedicated to providing highly individualized care for patients with orthopedic injuries. Insurance companies will not dictate the care you receive at Progressive Physical Therapy, Inc. (PPT). Your plan of care is achieved through the professional assessment of your therapist and physician, and based on your specific functional goals. Please read the following policies and sign below.

1. Insurance: In order to maintain our high standard of care, PPT is contracted with many insurance companies. As a courtesy to you, the insured, PPT verifies insurance benefits and coverage at the time you begin our professional services. ***This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for and services rendered.*** It is your responsibility to make sure we have the most current information on your insurance so we may bill it on your behalf. You as the patient, or legal guardian, are responsible for all charges that the carrier does not pay on the claim including any denials, deductibles, co-payments and co-insurance due. You are also responsible for knowing the benefits provided by your insurance coverage including coverage, exclusions and limitations. In the event your insurance company forwards payment directly to you, instead of to Progressive Physical Therapy, Inc., you are required to immediately deliver such payment to Progressive Physical Therapy, Inc. You also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for any costs and court costs, in addition to the outstanding balance.

*As verified on \_\_\_\_\_, we expect your insurance company to cover \_\_\_\_\_% of the amount they consider reasonable and customary charges. Your portion should be the remaining \_\_\_\_\_% plus any additional amount not paid by your insurance company. Additionally, there is/is not a co-payment of \$\_\_\_\_\_ due at each visit. **Please also note that deductibles must be met prior to insurance payments made on your behalf.** Progressive Physical Therapy is not responsible for verifying deductible or co-payment amounts.*

2. Authorization to furnish information: I hereby authorize Progressive Physical Therapy, Inc. to release all medical records concerning my health care to my physician(s), insurance representative(s), insurance carrier(s) and/or legal representative(s). Medical information and records may be released by facsimile, telephone, and mail. I also authorize my insurance carrier(s) to pay Progressive Physical Therapy, Inc. directly for any services rendered.

3. Automobile Accidents: You are responsible for your bill at the time of service. If we can verify that liability has been accepted by the insurance company, that "medical payments" are available under the insurance coverage, and that bills are paid upon receipt (not at time of settlement), we will, as a courtesy to you, bill your insurance company if your credit card is on file with us. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. If payment for services rendered is not received within 30 days of billing, full payment will be due immediately and charged to your credit card.

4. Workers' Compensation: Authorization for treatment from your employer's insurance carrier or employer if self-insured, must be received by Progressive Physical Therapy, Inc. prior to onset of therapy. When the patient's initial authorization has expired or when the authorized physical therapy visits are used, Progressive Physical Therapy, Inc. must have re-authorization from the insurance carrier or employer (if self-insured) for physical therapy to continue.

5. Medicare: Our office accepts Medicare assignment. Medicare payments will come directly to us. The patient will be responsible for charges not paid or covered by Medicare which include but is not necessarily limited to the annual deductible, 20% of Medicare approved charges, which is the patient's co-insurance, costs past the annual \$1,880.00 CAP and any service not covered by Medicare. We will inform you prior to reaching your CAP or any uncovered service that we are aware of.

6. Durable Medical Equipment (DME) and Supplies: DME and supplies are not reimbursable by insurance companies, and must be paid for at the time of your therapy session.

7. Payment: Co-Payments are expected when services are rendered (each visit). For your convenience, we can accept payment on a weekly basis. If alternative arrangements are necessary, please contact us directly. We accept VISA, Mastercard, American Express, Discover, debit cards, checks and cash. We expect co-insurance accounts to be paid in full within 30 days from the last day of treatment.

8. Late Charges/Returned Checks: Any account that remains open beyond 30 days from last day of treatment will be subject to a \$10.00 fee for each month that the amount is not paid in full. There will be a \$35.00 fee for each returned check.

9. Canceled/Missed Appointments: If a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for the session. We require 24 hour notice for cancellations. Appointments that are canceled with less than 24 hours notice or no show appointments are subject to an \$85 charge, which is not reimbursable by insurance companies. Also, if a patient late cancels or no-shows more than two times, the patient is responsible for the full charge of the visit and will be taken off of the schedule for any future appointments.

10. Right to Triage: PPT will make every endeavor to see you at your convenience. However, PPT reserves the right to triage clients on emergency cases. You may have to be treated by another therapist. This is our team approach to treatment.

11. Fees: Our fees are subject to change without notice. Please see our fee schedule for all charges. After the initial evaluation, subsequent physical therapy sessions are billed in 15 minute increments and typically range from 30 to 60 minutes in length. As the law requires, each visit will be documented by the therapist during that visit and is part of that visit's time.

12. Consent for Treatment: The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures/modalities as requested by the physician prescribing care. Even though your doctor has referred you to therapy for a certain number of visits or length of time, the therapist will monitor your progress and adjust your treatment accordingly.

13. Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and the services you receive at PPT. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by PPT. We are required by law to make sure that medical information that identifies you is kept private and give you notice of our legal duties and privacy practices with respect to medical information about you.

I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at PPT.

If a patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent or guardian(s) signature for authorization allows PPT to commence physical therapy, occupational therapy and/or speech therapy treatments with the patient who is a minor. The parent or guardian is also accepting full financial responsibility for the treatment.

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's or Guardian's Signature: \_\_\_\_\_  
(If patient is under 18 years)

\*\*\*\*\*  
Per the policies described herein, we ask that you authorize us to automatically charge your portion of the bill to your Visa, MasterCard, Discover or American Express.

I hereby authorize: Progressive Physical Therapy, Inc.  
19510 Ventura Boulevard, Suite 106  
Tarzana, California 91356

to apply my balance to my charge card account.

Visa  MasterCard  American Express  Discover

Account Number: \_\_\_\_\_ Expires \_\_\_\_\_ Security Code \_\_\_\_\_

\_\_\_\_\_  
Cardholder's Signature Date



**Medicare Assignment of Benefits:** I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Progressive Physical Therapy, Inc. This authorization shall apply to the period:

\_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Patient Name

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

\_\_\_\_\_  
Date



## PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Progressive Physical Therapy, Inc.'s Notice of Information Practices. I understand that Progressive 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 Progressive 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 acknowledge the use and disclosure of my personal health information for purposes as noted in Progressive 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

I authorize Progressive Physical Therapy, Inc. or its assigns to contact me by using the email address listed below. I have received a copy of Progressive Physical Therapy, Inc.'s "E-mail Confidentiality Notice" dated 6/1/2005. If I wish to discontinue getting emails from Progressive Physical Therapy, Inc., I will revoke this authorization in writing.

I 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

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I authorized Progressive Physical Therapy to also share information directly to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship