SANTA MONICA PHYSICAL THERAPY

Name: _____ Date: _____

SSN: _____ DOB: _____ Age: _____

Home address: _____ City: _____ Zip Code: _____

Home phone number: _____ Cell phone number: _____

Email: _____ Driver's License Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone number: _____

If patient is not the primary insurance holder, please give name and date of birth of the person listed on the insurance policy.

Name of primary insurance holder: _____ Date of Birth: _____

If patient is a minor, please give name and address of person legally responsible.

Name: _____ Relationship: _____ Date of Birth: _____

Phone: _____ Billing Address: _____

In the case of an emergency, please provide contact information of nearest relative.

Name: _____ Relationship: _____

Phone: _____ Address: _____

****Please note we are an educational facility****

I understand that I may be seen by a student Physical Therapist under the direct supervision of a licensed Physical Therapist.

Signature: _____

Authorization to release information: I hereby authorize Santa Monica Physical Therapy, Inc. to release any information acquired in the course of evaluation or treatment of the patient to any person or entity which is or may be liable for all or any portion of Santa Monica Physical Therapy's charges. A photocopy of this form shall be deemed as valid as the original.

Date: _____ Signature: _____

Patient/Parent/Guardian

Assignment of Insurance Benefits: The undersigned authorizes direct payment to Santa Monica Physical Therapy, Inc. of any insurance benefits otherwise payable to the undersigned for professional service charges. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Date: _____ Signature: _____

Patient/Parent/Guardian

Patient Medical History

Date of injury or symptom onset: _____

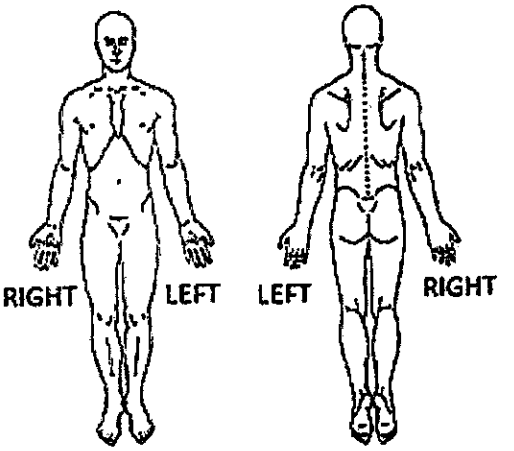
Surgery/procedure performed and date:

_____

Date of next appointment with referring provider:

_____

On the following diagram to the right, indicate and label where you have your current pain and/or symptoms.



Past Medical History

			If YES, please specify (include dates/treatment):
History of Cancer	YES	NO	_____
Cardiovascular Disease	YES	NO	_____
High Blood Pressure	YES	NO	_____
Cerebral Vascular Accident (Stroke)	YES	NO	_____
Diabetes Mellitus (Type 1 or Type 2)	YES	NO	_____
Immunosuppression	YES	NO	_____
Autoimmune Disease	YES	NO	_____
Fibromyalgia	YES	NO	_____
Osteoporosis / Osteopenia	YES	NO	_____
Osteoarthritis	YES	NO	_____
Currently Pregnant	YES	NO	_____

Other condition, please describe:

_____

Please list results (or include copy of results) of recent diagnostic studies (X-rays, MRIs, CT scans, PET scans, bone density, blood work, etc.):

_____

_____

Current medications, include dosage and start date (or include copy):

_____

_____

Have you had home health services of ANY KIND including nursing, physical therapy, occupational therapy, speech therapy, etc.?

YES NO If YES, when was the discharge date: _____

Have you had other physical therapy, occupational therapy, or chiropractic treatments this year?

YES NO If YES, please indicate when and how many: _____

Prior level of function, please include specific activities and/or sport participation:

_____

Santa Monica Physical Therapy, Inc. Financial Policy

Thank you for choosing Santa Monica Physical Therapy as your health care provider. We are committed to your treatment being successful. The following is our financial policy. Please read and sign the statement prior to initiating any treatment.

1. All patients must complete the information sheet.
2. **Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payments, co-insurance, visit limitations, and any pre-authorization requirements. As a courtesy, we will also verify your coverage but will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are ultimately responsible for knowledge of insurance benefits and for the full payment of your bill.**
3. Co-payments or co-insurance payments are due each visit.
4. If you do not have insurance, full payment is due at time of service.
5. We accept cash, checks, and most credit cards.

We bill insurance companies as a courtesy of our patients. However, you are ultimately responsible for co-payments, co-insurance or any part of the bill not paid by your insurance company. In trying to reduce their own costs, some insurance companies have lately developed a policy of unilaterally declaring "medical necessity has not been established" for portions of treatment. You are still responsible in this case for the services that were rendered.

In order for us to bill an insurance company, patients must provide us with the following documents:

a. A current physician's prescription ordering physical therapy and including a diagnosis, frequency and duration of treatment (updated as necessary).
b. A copy of insurance card.

Please be advised that this office will require payment in full for treatments rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is also your responsibility to check with your insurance company the status of your claim.

Depending on your insurance plan, you might be required to pay a co-payment or co-insurance for services rendered. This can be a fixed dollar amount per visit (co-payment), or a percentage of the charge for the visit (co-insurance). Since we will not be able to ascertain the exact dollar amount of a co-insurance payment in advance, we will estimate that amount and collect it at each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check to you if over-payment is determined. Payment is expected within 15 days of the date of the statement, a finance charge of 1.5% will be assessed on all delinquent accounts.

I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including numbers of visits, deductible amount, requirement of pre-authorization (when indicated), and coinsurance or co-payment amounts.

Our cancellation policy is a $75.00 fee for any missed appointments or cancellations without 24 hours notice.
There are no exceptions and additional appointments cannot be scheduled until fee is paid.

Please let us know if we can help you with any of the above information.

By my signature below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to, any services or fees denied or not covered by my insurance company. I certify that I have read and fully understand all of the above information.

_____ _____

Signature of patient or responsible party Date

SANTA MONICA PHYSICAL THERAPY, INC. HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION.

PLEASE REVIEW IT CAREFULLY

Santa Monica Physical Therapy, Inc. is committed to maintaining and protecting the confidentiality of out patients' medical, personal, and sensitive information. We are required by federal and state law to protect the privacy of your individual identifiable health information and other personal information and send you this Notice about our policies, safeguards, and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notices, if we revise it.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer, or worker's compensation carrier. For example, your insurer may request and receive information on dates of service, the type of services provided, and the medical condition being treated.

Health Care Operation: Your health information may be used as necessary to support the day-to-day activities and management of **Santa Monica Physical Therapy, Inc.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Lawsuits and Disputes: Your health information may be disclosed in response to a court or administrative order. For example, if you are involved in a lawsuit or dispute and **Santa Monica Physical Therapy, Inc.** is served with a subpoena, warrant, summons, or other lawful process this office may be required by law to disclose your health information.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state Public Health Department.

Information about Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Appointment Reminders: Your health information may be used by our staff to contact you regarding appointment openings and reminders. If you have any concerns about us leaving messages or information pertaining to appointment dates and times with other household members, please let us know. No confidential patient information will be left by phone.

Other uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified **Santa Monica Physical Therapy, Inc.**

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend and submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policy and practices may be required by changes in federal and/or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to our office.

If you feel that your privacy rights have been violates, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

I ACKNOWLEDGE that I have received a copy of Santa Monica Physical Therapy's notice of privacy practices. I understand that this information describes how Santa Monica Physical Therapy may disclose and use my protected health information:

Patient's Name:_____**(please print)**

Patient Signature:_____

Date:_____

This Notice is effective on or after June 01, 2019