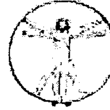
NAME:______________________ DATE:____________



Skypark Physical Therapy
23332 Hawthorne Boulevard, Suite 202
Torrance, CA 90505
(310) 373-5288 • Fax (310) 373-6223

Medical History

Please provide your detailed medical history by filling out this form. This is a requirement by Medicare for us to keep a detailed record of your health history.

Personal History

Please check ✓	Yes	No
Heart disease	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐
Kidney or bladder dysfunction	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Respiratory disease	☐	☐
Pneumonia or emphysema	☐	☐

Please check ✓	Yes	No
Tuberculosis	☐	☐
Asthma	☐	☐
Hepatitis	☐	☐
Anemia	☐	☐
Bleeding disorder	☐	☐
Hernia	☐	☐
Thyroid dysfunction	☐	☐
Congenital abnormalities	☐	☐
Surgical implants	☐	☐
Pacemaker	☐	☐
Are you pregnant?	☐	☐

Please list all surgeries, invasive medical procedures, fractures and other serious injuries. Include approximate date and any lasting complications or disabilities:

____

____

____

Please list present medications that you are taking:

____

____

Do you have any allergies to the following?

Please check ✓	Yes	No
Novocaine / Lidocain	☐	☐
Iodine compounds	☐	☐

Other (please list):____________________

Your weight:__________Height:__________

Family History

Has any immediate family relative ever had any of the following:

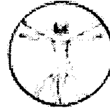
Please check ✓	Yes	No
Heart disease	☐	☐
Heart Attack	☐	☐
Rheumatic fever	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐

Please check ✓	Yes	No
Epilepsy	☐	☐
Kidney or bladder dysfunction	☐	☐
Diabetes	☐	☐
Cancer	☐	☐

I certify that this information is correct and true: X______________________ ___/___/___

Signature date

NAME:______________________ DATE:____________



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Patient Information

Full name: ______________________________

Address: ______________________________ Employer & occupation: ______________________________

City: ______________ State: _____ Zip: _____ Address: ______________________________

Home phone #: ______________________________ Work phone/pager/cellular #: ______________________________

Birth date (mn/day/yr): ______________________________ Driver's license # (required): ______________________________

If under 18, guardian name: ______________________________ Social Security # (required): ______________________________

Gender: male ☐ female ☐ E-mail (optional): ______________________________

Emergency contact: ______________________________ Relation: ______________ Phone: ______________

Friend/relative not living with you: ______________________________ Phone: ______________________________

Referred by (physician, friend, etc.): ______________________________ Phone: ______________________________

Billing and Insurance

Insurance (✓ those that apply): ☐ Medicare ☐ W/C ☐ Private ☐ Cash ☐ Other

Insured Party: Self ☐ Spouse ☐ Other ☐

Is condition: Work ☐ Auto ☐ Other ☐

Name of insured: ______________________________

Date of injury / onset: ______________________________

Reason for referral / condition: ______________________________

Please provide insurance information of all applicable policies that may cover services while under our care:

Insurance: ______________________________ Insurance: ______________________________

Group / Policy #: ______________________________ Group / Policy #: ______________________________

ID: ______________________________ ID : ______________________________

Claim #: ______________________________ Claim #: ______________________________

Phone #: ______________________________ Phone #: ______________________________

Adjuster: ______________________________ Adjuster: ______________________________

Please submit your insurance card(s) and Driver's License for photocopy to maintain in your medical records (this is required)

For patient's with attorney representation / personal injury

Attorney: ______________________________ Phone: ______________________________

Contact person: ______________________________ Fax: ______________________________

Accountability and Patient's Rights

My signature below certifies the information contained herein as correct and true. I understand that I am ultimately financially responsible for services provided regardless of insurance payment or legal representation. As designated legal guardian for this patient, my signature authorizes treatment for this minor.

Patient's Rights'. I understand that I have the right to:

- Respectful and courteous care regardless of race, religion, gender, nationality, orientation, age or disability
- Participate in my healthcare treatment plan
- Continue to self-pay for services after insurance benefits have ceased
- Be informed of risks / benefits of treatment and alternatives
- Choose my own therapist, and know their qualifications
- Grant or deny access of my confidential medical records to other persons or agencies

X______________________________

Signature of patient or guardian Date

Office use only Onset date: ______________

Dx code 1: ______________ Dx code 2: ______________

Dx code 3: ______________ Dx code 4: ______________

Admit condition (0-10) ______________________________

Skypark Physical Therapy
23332 Hawthorne Blvd., Ste. 202
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Financial Policy

Please read and sign our financial policy. Check only what applies to you, then sign and date the bottom statement. Your signature is required before rehabilitation services can be provided at our facility:
Check insurance/payment type that applies:

☐ Medicare: Our facility accepts Medicare reimbursement for rehabilitation services. Payment from Medicare only covers approximately 80% of rehabilitation services; therefore your secondary insurance (Medi-gap) is responsible for the remaining 20%. Our facility cannot bill for additional expenses or charges not covered by Medicare and secondary policies and must accept reimbursement as payment in full.
Exceptions:

- If you have not met your annual $100.00 deductible, you are rightfully responsible to pay this.
- Your secondary insurance has a deductible, or limited reimbursement, which requires you to pay the remaining applicable balance.
- Our office will notify when you reach the number of visits allowed per your diagnosis.
- You desire to continue treatment after benefits have ceased, therefore you may elect to self-pay (i.e. cash).
- You received physical or speech therapy elsewhere and did not disclose this Medicare will allow 0 and you will be 100% responsible.
- You were involved in litigation (i.e. car accident, slip and fall) for which liability insurance should cover medical care primarily. If this information was not disclosed and settlement was made, you may be required to reimburse Medicare for any payment made to our facility.
- If you do not have a secondary insurance, you will by billed the 20% Medicare allowed.

☐ **Private Insurance**: ***As a courtesy to our patients, we will bill your insurance company for you and withhold action for 45 days. If your insurance has failed to pay within 45 days we will expect you to pay your bill in full, & seek reimbursement from your*** *insurance*. We will also assist you in verifying your insurance benefits. Any remaining balance, co-pay, delinquent payment or deductible amounts due for services rendered are your responsibility. ***Co-payments are due at the time of visit.*** Delinquent, late or overdue balance amounts may accrue interest. If you are unable to keep your appointment, please provide a 24-hour notice of cancellation. If you do not, ***you will be charged $5.00 for canceling less than 24 hours and $10.00 if you do not cancel at all.***

☐ Cash: Our facility will accommodate check or credit card payment plans in the event of non-payment from insurers, out-of-network plans, or non-coverage of rehabilitation services. I agree to pay: $________ (initial) X____________________

☐ Liens: We will accept lien agreements provided that an attorney represents you. Both you and your attorney are required to sign a lien document. In the event of a discontinued litigation case, or if you are not successful in winning your litigation, you are ultimately financially responsible for services rendered. *Please sign and attach a lien document form to this file.* If you are unable to keep your appointment, please provide a 24-hour notice for cancellation. If you do not, ***you will be charged $5.00 for canceling less than 24 hours or $10.00 if you do not cancel at all.***

☐ **Worker's Compensation**: As a courtesy to our patients we will bill your insurance & withhold action within 45 days. If you are covered (authorized) by your employer's Worker's Compensation benefits, you are not liable for any additional payments. If you are unable to keep your appointment, please provide a 24-hour notice for cancellation.

☐ **Worker's Compensation Liens**: We will accept lien agreements providing you sign a lien document. If you have filed a fraudulent claim, and no payment settlement is made, then you are ultimately financially responsible for services rendered. If you are unable to keep your appointment, please provide a 24-hour notice for cancelation.

AUTHORIZATION TO RELEASE RECORD:
I hereby authorize Skypark Physical Therapy to release my medical records to my attorney, my insurance company or Skypark Physical Therapy representatives for collection and also to myself upon my request.

I have read and fully agree to this information presented: X ________________________________

Signature of patient or guardian Date:

NAME:______________________ DATE:______________

Notice of Privacy Practices

Skypark Physical Therapy
23332 Hawthorne Boulevard, Suite 202
Torrance, CA 90505
(310) 373-5288 • Fax (310) 373-6223

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At Skypark Physical Therapy, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give this notice, and to follow the terms of this notice.
- The law permits us to disclose or use your health information to those involved in your treatment. For example, a review of your file may be given to a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information.
- We may also want to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family remember or another person responsible for your care.

- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above.
- We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with our health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whichever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing and if you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include you statement in your files. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice. we will notify you of the changes in writing.

You may file a complaint with the **Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201**. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at **(310) 373-5288**. This notice goes into effect as of April 14, 2003.

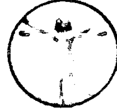
<u>Acknowledgement</u>

I have received a copy of the Skypark Physical Therapy Notice of Privacy Practice.

Date ____________________

Signed ____ Print Name __________________________________

If signing as a parent or guardian, please note the name of the patient ____



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ASSIGNMENT FOR DIRECT PAYMENT

I HEREBY AUTHORIZED PAYMENT BY CHECK BE MADE OUT DIRECTLY TO:

Skypark Physical Therapy
23332 Hawthorne Blvd, Ste 202
Torrance, CA 90505
310/373-5288
TIN 33-0152163

FOR THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD CHARGES FOR PROFESSIONAL SERVICES RENDERED BY SKYPARK PHYSICAL THERAPY. THE PAYMENT WILL NOT EXCEED MY INDEPTENDNESS TO THE ABOVE MENTIONED ASSIGNED AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT YOU TO MAKE OUT THE CHECK TO ME, AND MAIL IT TO ME IN CARE OF SKYPARK PHYSICAL THERAPY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

____________________________ ________________
SIGNATURE OF PATIENT DATE

Patient Name:____________________________ MD:____________________________
DX:______________________________________ MR#:_____________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give 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

I wish to be contacted in the following manner (Check/Circle all that apply)

VOICE COMMUNICATION

HOME =___________ WORK =___________ CELL =___________ TEXT =___________

_Ok to leave message with detailed information: Home Work Cell Text Other
_Leave message with call back number only : Home Work Cell Text Other

_The following people are authorized to receive my medical information:

Name:_______________ Phone: (___)____________ Relationship:_______________

Name:_______________ Phone: (___)____________ Relationship:_______________

Name:_______________ Phone: (___)____________ Relationship:_______________

WRITTEN COMMUNICATION

_OK to mail to home address
_OK to mail to work/office address
_OK to mail to a different address: ________________________________
_ Home fax: (___)___________________
_ Work Fax: (___)___________________

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... Healthcare entities must keep records of PHI disclosures.

I have received Skypark Physical Therapy/Westside Physical Therapy, Notice of Privacy that provides a more complete description of information uses and disclosures, I understand that it may become necessary to disclose my PHI to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the Notice of Privacies Policies. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information to revoke this consent by following the procedures outlined in the Notice of Privacy Policies. However, Skypark or Westside Physical Therapy is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Notes: Uses and disclosure for treatment, payment, operations (TPO) information may be permitted without prior consent in an emergency.

____
Signature of Patient/Parent/Guardian **Date**

____
Print Name **Name of Patient (if different)**

Skypark Physical Therapy 23332 Hawthorne Blvd., Suite 202, Torrance, CA 90505
(310) 373-5288 fax (310) 373-6223 WWW.SKYPARKPT.BIZ