Functional Physical Therapy and Rehabilitation

Date of First Visit _____ Date of Injury/Onset/Surgery: _____

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S M D W DL#: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Sex: Male Female Type of Accident: Auto Work Other Date of Accident:_____

Home Phone #:_____ Work Phone #:_____

Employer Name: _____

Employer Address:_____ City: _____ State:_____ Zip:_____

If this is for a work related injury ask the following:

Does your employer have an MPN? **Yes** ☐ **No** ☐

If yes, are we members of the MPN? **Yes** ☐ **No** ☐

If we are not on the MPN whom do we call to get on the MPN?

Referring Physician: _____ Phone #: _____

Date of last MD Visit: _____ Diagnosis: _____

Prescription Frequency & Duration: _____

Referring Attorney: _____ Phone #: _____

Attorney Address: _____

City, State, Zip: _____

In case of emergency: _____ Phone #: _____

Have you had PT, OT, Speech, Chiro, Accupuncture this year? _____ How many visits? _____

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Group #: _____ Policy #:_____

Adjustor Name: _____ Phone #: _____

Claim #: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Group #: _____ Policy #:_____

Information taken by: _____ Date: _____

Functional Physical Therapy and Rehabilitation

2245 E. Colorado Blvd. #202
Pasadena, CA 91107
(626) 449-9910 voice • (626) 449-9382 fax

PATIENT HISTORY FORM

Name:_____ Gender:_____ Date of Birth:_____

Do you now have, or have ever had, any of the following (please circle one)?

Diabetes	Yes	No	Allergies	Yes	No
High Blood Pressure	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Seizures	Yes	No
Chronic Headaches	Yes	No	Metal Implants	Yes	No
Liver / Kidney Conditions	Yes	No	Dizziness	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No
Bone Disease / Fractures	Yes	No	Osteoporosis	Yes	No
Bowel / Bladder Conditions	Yes	No	Anemia	Yes	No
Breathing Conditions	Yes	No	Depression	Yes	No
Circulatory Disease	Yes	No	Glaucoma	Yes	No
Heart Conditions	Yes	No	Corneal Implants	Yes	No
Stroke / CVA	Yes	No	Smoker	Yes	No
Thyroid Conditions	Yes	No	Currently?	Yes	No
Hernia	Yes	No	Other illness	Yes	No

If **YES** to any of the above, please: explain, give dates, and appropriate details:

_____

_____

_____

_____

Are you currently pregnant (please circle one)? Yes No N/A

List any medications you are currently taking:

_____

_____

Have you ever had physical therapy treatments for this current problem before (please circle one)? Yes No

If **YES**, indicate where, when, and was the treatment effective:

_____

_____

_____ _____

Patient's Signature Date

Functional Physical Therapy and Rehabilitation

2245 E. Colorado Blvd #202
Pasadena, CA 91107
(626) 449-9910 Fax (626) 449-9382
Tax ID: 84-5142167

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Functional Physical Therapy, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Functional Physical Therapy, Inc. to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Functional Physical Therapy, Inc., and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

Functional Physical Therapy, Inc.
2245 E. Colorado Blvd #202
Pasadena, CA 91107

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

Functional Physical Therapy and Rehabilitation

Information Release Authorization

I hereby consent to the release and disclosure of my personal health information to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

For the following purpose:

_____

_____

_____

This release authorization includes my personal health information consisting of:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of Functional Physical Therapy having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature **Date**

FUNCTIONAL PHYSICAL THERAPY AND REHABILITATION

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

FUNCTIONAL PHYSICAL THERAPY AND REHABILITATION

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare <u>will not pay</u>

- Medicare does **not** pay for all of your health care costs**.** Medicare only pays for covered benefits**.** **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
Before you make a decision, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you **(Estimated Cost: $ _____)**

Medicare will not pay for: PT & SPEECH LANGUAGE PATHOLOGY SERVICES OVER $1740 PER YEAR

☒ 1. **Because it does not meet the definition of any Medicare benefit**

☐ 2. **Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items
- ☐ Most shots (vaccinations)
- ☐ Hearing aids and hearing examinations
- ☐ Most outpatient prescription drugs
- ☐ Orthopedic shoes and foot supports (orthotics)
- ☐ Health care received outside of the USA
- ☐ Services required as a result of war
- ☐ Routine physicals and most tests for screening
- ☐ Routine eye care, eyeglasses and examinations
- ☐ Cosmetic surgery
- ☐ Dental care and dentures (in most cases)
- ☐ Routine foot care and flat foot care
- ☐ Services by immediate relatives
- ☐ Services under a physician's private contract
- ☐ Services paid for by a governmental entity that is not Medicare
- ☐ Services for which the patient has no legal obligation to pay
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF
- ☐ Services of an assistant at surgery without prior approval from the peer review organization
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Patient Name: _____

Patient Signature: _____

Date: _____

This notice explaining exclusions from Medicare benefits is published by the Centers for Medicare & Medicaid Services