physical therapy + Pilates = optimal movement

[ ] Costa Mesa [ ] Fountain Valley [ ] Huntington Beach [ ] Irvine [ ] Newport Beach

PATIENT INFORMATION

Name: _____ Patient ID #: _____
Address: _____ Date of Birth: _____
_____ Social Security #: _____
City, State, Zip: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced
Email: _____ Primary Physician: _
Phone: ( ) _____ [ ] Home [ ] Work [ ] Other
Phone: ( ) _____ [ ] Home [ ] Work [ ] Other How did you hear about us: _____
Employer: _____ Referring Physician: _____
Employer Phone: ( ) _____
Was this an injury? ____ Yes ____ No Date of Injury: _____
Where did Injury Occur: [ ] Work [ ] Auto [ ] Home [ ] School [ ] Other: (Specify) _____

GUARANTOR

[ ] Same as Patient
Name: _____ Employer: _____
Address: _____ Phone: ( ) _____
_____ Social Security #: _____
City, Sate, Zip: _____ Date of Birth: _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other
Insured Party: _____ Relationship to Patient: _____
Insurance Carrier: _____ Social Security #: _____
Claims Address: _____ Insured ID / Cert. # _____
_____ Group # : _____
City, State, Zip: _____ Date of Birth: _____
Phone: ( ) _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other
Insured Party: _____ Relationship to Patient: _____
Insurance Carrier: _____ Social Security #: _____
Claims Address: _____ Insured ID / Cert. # _____
_____ Group # : _____
City, State, Zip: _____ Date of Birth: _____
Phone: ( ) _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____
Address: _____ Phone: ( ) _____
_____ City, State, Zip: _____

I hereby authorize and consent to examination and treatment as deemed necessary by Therapists of California Therapy Solutions. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by California Therapy Solutions in the collection of amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to California Therapy Solutions. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date: _____ Signature of Responsible Party _____

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Medical History

Name: _____

Type of Injury / Condition: _____ Onset / Injury Date: _____

Type of Surgery and Date: _____

Please 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

Have you had any imaging performed for this injury?

[ ] X-Ray [ ] MRI [ ] CT Scan [ ] Doppler [ ] Ultrasound

Have you recently noticed any of the following?

[ ] Weight Loss / Gain [ ] Weakness [ ] Pregnant / IUD [ ] Pain at night [ ] Nausea / Vomiting [ ] Fever / Chills / Sweats [ ] Headaches
[ ] Fatigue [ ] Numbness [ ] Tingling [ ] Vision loss [ ] Hearing Loss [ ] Insomnia

Do you now, or have you ever had any of the following? (Please mark all that apply)

[ ] Surgery [ ] Sprains / Strains [ ] Heart Problems [ ] Circulation issues (clots) [ ] Easy bruising / Bleeding [ ] Indigestion / Heartburn
[ ] Diabetes [ ] Cancer [ ] Asthma [ ] Leg / Ankle Swelling [ ] Fainting [ ] Fractures
[ ] High Blood Pressure [ ] Auto Accident [ ] Lung Disease [ ] UTI's / Incontinence [ ] Allergies
[ ] Any previous injury that may affect current care _____

Please explain and provide dates for any of the issues you marked above: _____

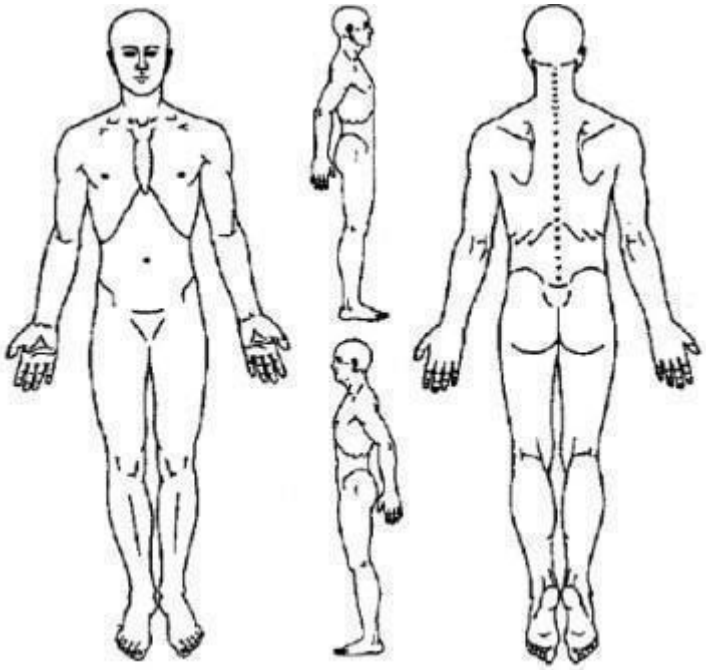
_____

Current Medications: _____

Type of Pain: [ ] Sharp [ ] Burning [ ] Aching [ ] Tingling [ ] Numbness [ ] Throbbing [ ] Other: _____

Please rate your pain level (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 is your treatment goal? _____



Please mark area(s) of concern

Signature: _____ Date: _____

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Insurance & Financial Policy for Physical Therapy Provided by California Therapy Solutions

_____ Initials ▪ Responsibility for payment of all bills pertaining to your care lies with you, the patient (or insured party, if not the patient).

_____ Initials ▪ **We strongly encourage you to contact your insurance company** at the start of your treatment to verify for yourself that these coverage and benefit **estimates** are correct, especially co-insurance payments, deductible amounts, and limitations to number or amount of treatment covered.

_____ Initials ▪ As a courtesy to you, we will provide you with an estimate of anticipated out-of-pocket costs that you may expect to incur during your treatment. Please understand that this is an **estimate only**, and your insurance company ultimately determines the amount of your liability at the time of processing of claims.

_____ Initials ▪ In the event your insurance company denies your claim in full or in part, or requests a refund for services already provided, you understand that you are liable for the full cost of your treatment.

_____ Initials ▪ If you find discrepancies with our information or have any questions concerning your coverage and liability, **please contact us immediately**.

_____ Initials ▪ Payment of patient co-pays, co-insurance and deductible amounts is due at time of service unless prior arrangements are made.

_____ Initials ▪ $ _____ = Deductible Remaining at time of first visit

_____ Initials ▪ $ _____ = **Estimated** Patient Co-Insurance/Co-Pay per Visit

We bill your personal insurance carrier solely as a courtesy to you. If your insurance carrier does not remit payment within 60 days, the balance owed will be due, in full, from you. 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.

RETURNED CHECKS

A **$25.00** fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

Cancellation Policy for Physical Therapy provided by California Therapy Solutions

A **24 hour notice is required** in the event of a cancellation. Patients who are no shows will be subject to the same charges. Failure to provide such notice will result in a **charge of $40**, which will not be covered by insurance. A credit card number must be kept on file in the event of late cancellations or no shows. Credit card information must be submitted before scheduling can occur. If you are uncomfortable leaving your credit card information on file, we would be happy to accept a refundable check or cash deposit.

Credit Card Info:

Circle One: Visa / MasterCard / Discover

Credit Card #: _____

Expiration Date: _____ 3 Digit Security Code: _____

BY SIGNING BELOW, I UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS AND ACKNOWLEDGE MY RESPOSIBILITY FOR THE PAYMENT OF ALL BILLS PERTAINING TO MY TREATMENT

_____

Patient Name (Please Print)

_____

Signature of Patient (or Patient's Guardian if under 18 years of age) Date

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NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for worker's compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or in certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: we reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

By my Signature below I acknowledge receipt of a copy of the Notice of Privacy Practices

Patient / Representative Signature: _____ Date: _____

E-MAIL CORRESPONDENCE AUTHORIZATION: *California Therapy Solutions uses video, photos and typed instructions for patient education and home exercise programs.*
I authorize the use of my email to send my home programs by California Therapy Solutions. Neither, my face, identity, nor name will be transmitted in this correspondence.

Signed _____ ***Date*** _____

California Therapy Solutions

MEDICARE PATIENT NOTIFICATION

To Our Medicare Patients:

- **PRESCRIPTION:** Please be advised that Medicare requires that you have a prescription from a Physician to receive services.

- **PLAN OF CARE:** Your therapist will develop a "Plan of Care" for your physician to approve. This plan is reviewed and re-certified by your Doctor every thirty days thereafter.

- **THERAPY "CAP":** The Federal Government has placed a "cap" (limitation) on your physical therapy benefits. The maximum that Medicare will pay for physical therapy is **$2010.00** for calendar year **2018**. This effectively translates into an approximately **15** visit limit**.** Please let us know if you have previously received physical therapy or speech therapy elsewhere this year.

- **SPECIAL EXCEPTIONS:** In many circumstances your diagnosis will allow treatment beyond the "cap." If you wish for your treatments to exceed the "cap", you are responsible for any amount that is not covered by either Medicare or any secondary insurance coverage you might have. Visits beyond the "cap" will be charged to you at our usual and customary visit charge.

- **YOUR COSTS:** Unless you have secondary insurance that covers your cost, you are responsible for an annual deductible of $183.00 and the 20 % co-insurance amount.

- **ADVANCED BENEFICIARY NOTICE:** Please sign the attached Advanced Beneficiary Notice form indicating that you are aware of the costs that may incur, if you exceed your Medicare cap. You will need to choose whether or not you agree to continue treatment if your "cap" is exceeded.

Have you had Home Health Care via Medicare this year? **Yes** **NO**

Please feel free to ask us if you have any questions or concerns.

_____ _____

Patient or Responsible Party Date

_____ _____

Print Name Therapist Initials

I have read and understand the above statements regarding my Medicare physical therapy benefits. I am responsible for all treatment charges, beyond the Medicare "cap," whether or not they are covered by insurance, unless prior arrangements have been made with CTS.

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Please list all medications you are currently taking, including all prescription and over the counter medications, any vitamins, supplements, and topical ointments.

Medication Name	Dosage (mg)	Frequency (x/day)	Route (pills, powder, etc.)

For additional items, please continue on the back of this sheet

I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Signature (or Patient's Guardian if under 18) Date

_____ _____

Patient Name (print) Employee Initials

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January 1, 2016

Dear Patient,

Here at California Therapy Solutions we are not only committed to superior therapeutic care, but also strive to further the Physical Therapy profession through the continuing education of our therapists and staff From time to time we allow students from USC, and other highly reputable programs of Physical Therapy, to intern in the clinic. They are primarily here to refine the practical application of their studies and are assigned to therapists who are responsible for their conduct and actions.

It may happen that you may be treated by an intern or that your therapist may have an intern with them during some of your treatments at our clinic. If this in any way causes you concern, discomfort or inconvenience, please let your therapist know and the student will be asked to excuse themselves during your therapy. If you have no objection to the student's presence and participation, then we thank you on their, and their university's, behalf for allowing them the opportunity to gain invaluable experience.

Our interns are at the culmination of their clinical training and it is a benefit to the patients to have interaction with intern as the patient will have increased one-on-one treatment time and the patient management will be implemented by both the physical therapist and the intern.

As always, if at any time you have questions concerning your care in our clinic, please feel free to talk with your therapist.

Thank you for your patience and willingness to help our future physical therapists.

CTS

- ☐ I have read and understand the above letter and I have no objection to having the intern administer treatment.
- ☐ I do not want the intern to administer treatment.

_____

Patient Signature

California Therapy Solutions

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Email and/or Text Message for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications or information at below referenced email and/or text from California Therapy Solutions.

_____ (***Patient initials***) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is:

(_____)_____-_____Carrier:_____

_____ (***Patient initials***) I consent to emails, to receive communications as stated above.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is:

_____

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature:

_____Date:_____

To Our Valued Patients:

In order to optimize your therapy, we ask that you please:

- **Arrive on time** for your appointment. This will assist in providing you the best care possible and the necessary one-on-one time with your therapist.
- **Sign In and Out** for treatment each day.
- Familiarize yourself with the **24-hour, advanced – notice cancellation policy**.
- **Schedule ahead 5-10 visits** to ensure your preferred appointment time and continuity of care**.**
- **Wear loose clothing appropriate for exercise.** Examples of items which would make treatment difficult to render are: jeans, skirts, and dress-shirts.

As a courtesy to our staff and other patients, we also ask that you:

- **Turn off your cell phone.**
- **Leave food and beverages outside of the clinic.**
- **Wash your hands** before treatment.
- **Remove your shoes** while on the treatment tables and equipment.
- **Wear Socks** to provide a barrier for your protection and that of your fellow patients.

Thank you,
The CTS Staff

Huntington Beach
18682 Beach Blvd,
Suite 130
Huntington Beach, CA 92648
Tel: 714.963.6600
Fax: 714.963.6900

Fountain Valley
9394 Warner Ave.
Fountain Valley, CA 92708
Tel: 714-964.3337
Fax: 714.964.8806

Costa Mesa/Newport Heights
485 E. 17th St.
Suite 650
Costa Mesa, CA 92627
Tel: 949.722.7374
Fax: 949.722.7644

Newport Beach
22 Corporate Plaza
Suite 113
Newport Beach, CA 92660
Tel: 949.722.5054
Fax: 949.999.3427

Irvine
6865 Alton Pkwy
Suite 110
Irvine, CA 92618
Tel: 949.679.2933
Fax: 949.679.2977

DID YOU KNOW?

The Physical Therapy Board of California licenses and regulates your Physical Therapist and Physical Therapist Assistant.

**A Physical Therapy Aide, while regulated by the Board, is not licensed.*

Visit the Board's website at www.ptbc.ca.gov for information on:

- **Verifying a license**
- **What to expect when you receive care**
- **Your rights as a patient**
- **How to file a complaint**

Board Contact Information
2005 Evergreen Street, Suite 1350
Sacramento, CA 95815
1-800-832-2251

Physical Therapy Board of California

Patient Acknowledgement of NTC 12 01

Disclosure Page

I have read, and understand the California Physical Therapy Board's Information informing me of the following:

1. The scope of Physical Therapy Aide's
2. The licensure of Physical Therapists, and Physical Therapists Assistants
3. The email address of the Physical Therapy Board, where I can get information on:
    a. Verifying a license
    b. What to expect when I receive care
    c. My rights as a patient
    d. How to file a complaint
4. The address of the California Physical Therapy Board

I, therefore, freely affix my signature below with full understanding of all the above.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____ _____

Signature of Patient Representative/Guardian Date

_____

Printed Name of Patient Representative/Guardian

_____ _____

Relationship of Patient Representative/Guardian Patient's Name being Represented

CA.GOV
CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS