Patient Information:

Last Name____________________________ First Name_____________________________________
Middle Initial ________
Referred By _______________________Doctor's Address ____
Date of Birth________________ Sex M/F _______ Doctor's Phone: _____________________________
Home Address_____________________________ City/State _____________________Zip________________
Home Phone______________________________ Work/Phone____________________________
Cell Phone______________________
Employer________________________________Occupation_______________________________________
Employers Address______________________________ City/State _____________________Zip__________
Employers Phone Number______________________ SSN______________________________ Drivers License Number__________________________
Emergency Contact_____________________ Telephone__________________ Relationship__________

SPOUSE AND/OR LEGAL GUARDIAN INFORMATION:

Name______________________________ Relationship____________________________
Home Address____ Telephone _____________________
Work Phone_________________________ Cell Phone _______________________________

Please Provide Proof of Insurance Coverage

Assignment & Authorization: I authorize the release of any medical information necessary to process insurance claims on my behalf. A copy of authorization shall be considered as valid as the original, and valid for the duration of my care in completion.

Signature __________________________________ Date_________________ WCAB#____________________

ABLE Physical Therapy

Treating the "WHOLE" Person!

Is This a Work Related injury? ____Yes ____ No (If Yes please Give date of injury DATE: ___________)

Were you involved in an automobile accident? ___ Yes ___ No
When did your injury occur or when did you first notice the pain? Date ___________________

Brief Description of injury (if this is not a work related injury, you are still entitled to fill out and explain when you first noticed pain):

____

____

____

LIST ANY CONDITIONS THAT YOU MAY HAVE: (example Cancer, Diabetes, Heart Problems, High Blood Pressure, Metal Implants, Pacemaker, Seizures)

____

____

____

Are you currently working ____Yes ____ No

Occupation: _________________

Have you had therapy before ____Yes ____ No

Where is your pain/problem ________________________________

Are you taking medication ____Yes ____ No

Please Circle one of each!

What is your pain level at lowest?

None Moderate Severe

0…1…2…3…4…5…6…7…8…9…10

What is your pain level at highest?

None Moderate Severe

0…1…2…3…4…5…6…7…8…9…10

How does the problem/pain affect your daily life? ___________________________________

____

____

If you are taking medication please explain what type of medication and how many times a day you are taking medication:

____

____

******* Do you have an attorney? If yes please give name, address, and phone number.**

____

____

Patients Signature

____

Date

PF-1000 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 INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures;

Treatment, your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and proving treatment. For example, results of laboratory 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.

Health care operations, your health information may be used as necessary to support the day to day activities and management of Able Physical Therapy Corp. 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 to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting

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's public health department.

Payment, your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Other uses and disclosures require you authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, you decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of you decision to revoke your authorization.

Additional Uses of Information

Appointment reminders, your health information will be used by our staff to send you appointment reminders.

Information about treatment, your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we may believe may be of interest to you.

Individual Rights

You have right under the federal privacy standards. These include;

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

Able Physical Therapy Corp Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right 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 policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Armando Kim. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can send a letter outlining your concerns to:

Susana Beltran
101 West Mission Blvd. Suite 110-397
Pomona, Ca 91766

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Patient Financial Policy

Thank you for choosing Able Physical Therapy Corp. for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the therapist. Able Physical Therapy Corp. participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.
2. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
3. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.
4. **NON-COVERED SERVICES:** Please be aware that some or perhaps all of the services you receive my not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.
5. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

6. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

7. **SELF-PAY:** If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service unless you make other arrangements with our financial counselor.

8. **NON-PAYMENT:** If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.

9. **PAYMENT METHODS:** We accept cash, personal checks, money orders, and cashiers check as payment for services rendered.

10. **RETURNED CHECKS:** A returned check fee of $25 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash, money orders, or cashiers check will be accepted.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Able Physical Therapy Corp. and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name:____

Responsible Party
(If not the Patient):____

_______________________________ _______________

Signature of Patient or Responsible Party **Date**

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Able Physical Therapy Corp reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Able Physical Therapy Corp

____

Name of Patient (print please)

____

Signature of Patient

____

Signature of Patient Representative
(For patient who is a minor or patient who cannot sign this form)

____

Signer’s relationship to patient

____

DATE