WELCOME TO OUR CLINIC

On behalf of the entire staff, we would like to welcome you to our clinic. We are pleased to have the opportunity to assist you with your physical therapy care. Our goal is to provide the highest quality and most up-to-date physical therapy treatments available in a professional and caring manner. We are committed to helping you attain your rehabilitation goals while providing you with outstanding service.

We would like to review a few of the office policies with you. We believe this will improve your understanding of how our office works, and will enable you to receive the maximum benefit from the physical therapy treatments you will receive.

Our office policies are as follows:

- Your appointment time begins at the time noted on the appointment card. Our goal is to keep your waiting time, if at all, to less than five minutes.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all of our clients.
- It is important to the recovery process that you keep all of your prescribed appointments. Should you need to cancel, kindly give 24 hours advance notice.
- We will call and verify your insurance benefits as a courtesy to you. You should, however, be aware of any limitations or stipulations your insurance may have regarding physical therapy care. We are not responsible for inaccurate or mistaken information from the insurance company regarding your benefits.
- We will provide your doctor with a report of your progress at the time of your follow up visit with him/her. Please notify us of your follow up appointment and any appointment changes that may occur so that we can prepare your report accordingly.

Whether you seek to resume pain free activities at home, work or play, we are confident you will find your experience at the office to be valuable in helping you reach your goals.

Thank you for choosing OrthoSport Physical Therapy. Should you have any questions or comments, please do not hesitate to reach out to us.

Yours truly,

Jennifer Manetta, *Owner, MPT* Rebecca McCloskey, *DPT* Kristin Cott, *Patient Relations*

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Preferred Method of Contact for appointment reminders: (Please Select Only One Option) ☐ Voice ☐ Text ☐ Email		If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work	
Date of Birth:	Male ☐ Female ☐	Doctor or Surgeon Name:	
Marital Status: (Circle One) Single Married Divorced Widowed	Social Security #:		
Employer Name:	Occupation:		
Emergency Contact Name & Phone #:	Relationship to Patient:		

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Member ID #:	Member ID #:
Group No.	Group No.
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Phone No.	Policy Holder's Phone No.
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Assignment of Benefits / Release of Information

I hereby authorize payment to OrthoSport Physical Therapy for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due. I authorize the release of any medical information necessary to process claims.

_____

Print Name Patient Signature Date

PATIENT HEALTH QUESTIONNAIRE

NAME_____ DATE _____/_____/_____

1. Please describe your current complaint/limitation and how it began _____

_____

2. When did your problem begin? _____ Specific Date if possible____/____/_____

3. What causes the pain/symptom to **INCREASE**?

_____

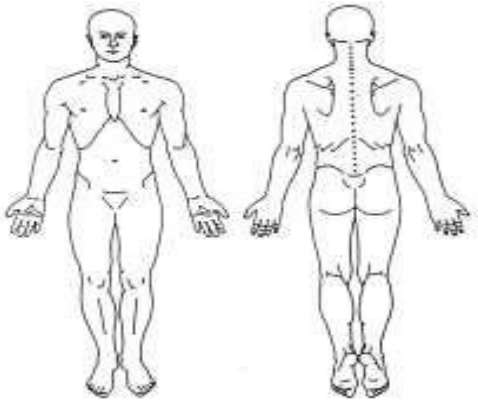
4. Your symptoms are worse: □ morning □ afternoon □ night □ during the day □ same all day

5. What causes the pain/symptom to **DECREASE?**_____

6. Please describe the nature of your pain:

□ Sharp pain	□ Constant	(76-100% of the time)
□ Dull Ache	□ Frequent	(51-75% of the time)
□ Throbbing	□ Occasional	(25-50% of the time)
□ Numbness	□ Intermittent	(25% or less)
□ Shooting		
□ Burning		
□ Tingling		

Mark on the picture where you have pain or other symptoms



7. Indicate the intensity of your pain **AT WORST**: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

CURRENT: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

AT BEST: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

8. **IN THE PAST,** have you been treated for the same problem? Yes No

□ MD □ Physical Therapist □ Massage □ Chiropractor □ Other _____

9. **CURRENTLY**, are you receiving other services for this condition? Yes No

□ MD □ Physical Therapist □ Massage □ Chiropractor □ Other _____

10. What is your **GOAL** for physical therapy?_____

11. Has your work status changed because of this condition? Yes No

12. What is your current work/school status? □ F/T, No restrictions □ P/T, No restrictions □ Retired □ Unemployed
□ F/T, with restrictions □ P/T, with restrictions □ F/T student □ F/T homemaker

13. Is this an injury as a result of a fall in the past year? Yes No

14. Two or more falls in the last year? Yes No

15. Have you been receiving Home Health Care ? Yes No

Next Page→

16. Please list all **MEDICATIONS/PRESCRIPTIONS** you are currently taking _____

_____

17. Please list all **ALLERGIES** _____

18. Please describe your **GENERAL HEALTH** (please circle) Excellent Good Fair Poor

19. Present **Weight**: _____lbs 15. **Height**: _____ ft _____in.

20. **FAMILY HISTORY**: Please check if any blood relative has had the following:

□ Hypertension	relation _____	□ Arthritis	relation _____
□ Diabetes	relation _____	□ Cancer	relation _____
□ Heart Disease	relation _____	□ Stroke	relation _____
□ Auto Immune	relation _____	□ Anemia	relation _____
□ Bleeding Disorder	relation _____	□ Other _____	relation _____

Are you CURRENTLY experiencing…….	Circle One	
Persistent, unrelenting pain	**Yes**	**No**
Excessive fatigue	**Yes**	**No**
Nausea/vomiting	**Yes**	**No**
Fever/chills/sweats	**Yes**	**No**
Unexplained weight change	**Yes**	**No**
Numbness or tingling	**Yes**	**No**
Changes in appetite	**Yes**	**No**
Difficulty swallowing	**Yes**	**No**
Bowel/ bladder dysfunction	**Yes**	**No**
Shortness of breath	**Yes**	**No**
Dizziness	**Yes**	**No**
Pregnancy	**Yes**	**No**
Depression	**Yes**	**No**
Abnormally high stress	**Yes**	**No**

Have you or your immediate family members ever been told you have….	Circle One	
Cancer	**Yes**	**No**
Diabetes	**Yes**	**No**
Hypertension	**Yes**	**No**
Heart Disease	**Yes**	**No**
Chest pain	**Yes**	**No**
Stroke	**Yes**	**No**
Osteoporosis	**Yes**	**No**
Auto Immune	**Yes**	**No**
Osteoarthritis	**Yes**	**No**
Anemia	**Yes**	**No**
Bleeding Disorder/Blood Clot	**Yes**	**No**
Tape/Latex Allergy	**Yes**	**No**

I certify that the above information is correct to the best of my knowledge. I will not hold OrthoSport Physical Therapy responsible for any errors or omissions that I may have made in the completion of this form. I will advise my therapist if there is a change in my physical condition which would alter my response to any questions on this form.

_____

Print Name Patient Signature Date

Financial and Office Policy

This is an agreement between OrthoSport Physical Therapy, as creditor, and the Patient/Debtor named on this form.
In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to OrthoSport Physical Therapy. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Payment arrangement if you have no insurance: You will need to pay by cash, check or credit card on the day the treatment is rendered.

Payment options if you have insurance: You are responsible for your deductible and any out of pocket portions at the time services are rendered. If your deductible due exceeds $400 you are subject to our deductible policy.

Deductible Policy: If your deductible due exceeds $400 you will need to pay TBD cash amount for the first visit and TBD cash amount thereafter until your deductible is met. This amount is a good faith payment which will be applied TOWARD your total deductible balance. You will receive a bill for the remaining amount.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days. The FINANCE CHARGE will be computed at the rate of (.83%) per month or an ANNUAL PERCENTAGE RATE of (9.96%) percent. The finance charge on your account is computed by applying the periodic rate (.83%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Any discounts offered must be paid at the time of service. We cannot bill you at a discounted rate.

Returned checks: There is a fee (currently $30) for any checks returned by the bank.

Missed appointment fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours' notice, a $25 fee will be charged. Patients with three missed appointments will be taken off the schedule and asked to call the day of for appointments.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records or have them sent to another doctor or organization. The amount of the fee is dependent upon the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Next Page→PAGE 2

IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1) If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:

   a) Do not write on the bill. On a separate sheet of paper write the following:

      i) Your name and account number.

      ii) A description of the error and an explanation (to the extent you can explain) why you believe it is an error.

      If you only need more information, explain the item you are not sure about and, if you wish, ask for evidence of the charge such as a copy of the charge slip. Do not send in your copy of a sales slip or other documents unless you have a duplicate copy for your records.

      iii) The dollar amount of the suspected error.

      iv) Any other information (such as your address) which you think will help OrthoSport Physical Therapy to identify you or the reason for your complaint or inquiry.

   b) Send your billing error notice to:

      OrthoSport Physical Therapy
      20101 SW Birch St.,#140
      Newport Beach, CA 92660

      Mail it as soon as you can, but in any case, early enough to reach OrthoSport Physical Therapy within 60 days after the bill was mailed to you. **You may telephone your inquiry, but *doing so will NOT preserve your rights under this law*.**

2) OrthoSport Physical Therapy must acknowledge all letters pointing out possible errors within 30 days of receipt, unless we are able to correct your bill during that 30 days. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill was correct. Once OrthoSport Physical Therapy has explained the bill, we have no further obligation to you even though you still believe that there is an error, except as provided in paragraph 5.

3) After we have been notified, neither OrthoSport Physical Therapy nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount tin dispute, but periodic statements may be sent to you, and the disputed amount can be applied against your credit limit. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. However, you remain obligated to pay the parts of your bill not in the dispute.

4) If it is determined that OrthoSport Physical Therapy has made a mistake on your bill, you will not have to pay any finance charges on the disputed amount. If it turns out that OrthoSport Physical Therapy has not made an error, you may have to pay finance charges on the amount in dispute, and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct, OrthoSport Physical Therapy must send you a written notification of what you owe; and if it is determined that we did make a mistake in billing the disputed amount, you must be given time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged to you.

5) If OrthoSport Physical Therapy's explanation does not satisfy you and you notify us ***in writing*** within 10 days after you receive our explanation that you still refuse to pay the disputed amount, we may report you the credit bureaus and other creditors and may pursue regular collection procedures, but we must also report that you think you do not owe the money, and we must let you know to whom such reports were made. Once the matter has been settled between you and OrthoSport Physical Therapy, we must notify those to whom we reported you as delinquent of the subsequent resolution.

6) If OrthoSport Physical Therapy does not follow these rules, we are not allowed to collect the first $50 of the disputed amount and finance charges, even if the bill turns out to be correct.

I have read and understand the above stated financial, office, and privacy policies.

Patient Signature: _____ **Date:** _____

Print Name: _____

Responsible Party (if different): _____ **Relation:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices.

I, (Patient Name) **_____ have read this office's Notice of Privacy Practices and understand the type of information we gather and with whom we share that information with.**

_____
(Patient's Signature)

_____
(Patient's Date of Birth)

_____
(Patient's Legal Representative / Parent) (Print) (If Patient Unable to Sign or Is a Minor)

_____
(Patient's Legal Representative / Parent) (Signature)

_____
(Date)

-FOR OFFICE USE ONLY-

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (Circle One):

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other, please specify: