PTCT
Physical Therapy Center
TUSTIN

Orthopaedics
Sports Medicine
Industrial

18102 Irvine Blvd.
Suite 207
Tustin, CA 92780

Phone: 714.505.2966
Fax: 714.505.2976

Brett Eirich
PT, ATC

Brenda Madsen
DPT, OCS

To: ALL PPO/Worker's Compensation Insured Patients

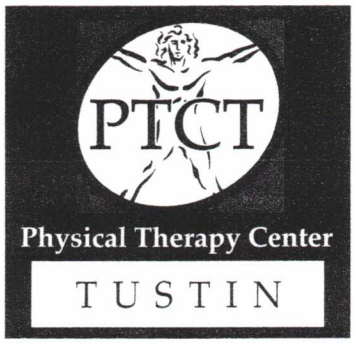
Re: Prescriptions

Medicare law states that physical therapy prescriptions are good for 30 days from the date written by your doctor. *For example, if your prescription is dated for January 1, 2012, then it will expire on January 31, 2012.* After your prescription expires, it is your responsibility to contact your doctor for a renewal. Without a current prescription your insurance company may deny payment.

If your doctor writes the prescription for less than 30 days, then your prescription will expire before that time.

_____ _____

Patient signature Date



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Please be aware at the time of your appointment, the amount of your co-insurance for your visit will be due. ***THIS IS ONLY AN ESTIMATE OF YOUR DEDUCTIBLE AND/OR CO-INSURANCE.*** *If you currently have not met your deductible, you will be responsible for the total amount of your visit. Once your deductible has been met you will be responsible for paying the amount your insurance does not cover. For example: if your insurance pays 80% then you will be responsible for the remaining 20%. As a courtesy, we will verify what this amount is or if your deductible has been met.*

_____ *Patient Initial*

PHYSICAL THERAPY CENTER OF TUSTIN INC.

Brett Eirich, PT, ATC

Patient Information

Name_____Date_____
Sex _____ Marital Status _____ Age _____ Date of Birth _____
Home Address_____ City _____ Zip _____
Home/ Cell Phone_____ Patient SS# _____
Email_____
Patient Employed By _____ Address _____
City _____ Zip _____ Phone _____
Spouse/Parent/Guardian Name_____ Date of Birth _____
Employed By _____ Address _____
City_____ Zip _____ Phone _____

INSURANCE INFORMATION

Is This A Work Related Injury? ____ Yes _____ No Date of Injury_____
Insured Full Name _____ Date of Birth _____ SS# _____
Name of Insurance Company_____ Policy/Group# _____
Mailing Address_____
Telephone_____ Employer _____

Do You Have a Secondary Insurance? ____Yes _____ No
Insured's Full Name_____ SS# _____
Name of Insurance Company_____ Policy/Group# _____
Mailing Address_____
Telephone_____ Employer _____

Referred To This Office By _____

In Case Of Emergency Notify _____ Telephone _____

AUTHORIZATION TO PAY

I hereby authorize the _____Insurance Company to pay by check made out and mailed directly to:

Physical Therapy Center Of Tustin Inc.

The medical and surgical expense benefits allowable and otherwise payable to me under my current Insurance policy as payment toward the total charges for PORESSIONAL SERVICES RENDERED. This payment will not exceed my Indebtedness to above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said PROFESSIONAL SERVICE. I also hereby authorize Physical Therapy Center of Tustin Inc. to furnish the Insurance company or others not authorized by law, will full information regarding treatment rendered, when requested.

_____ _____
Patient's Signature Insured's Signature

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PHYSICAL THERAPY CENTER OF TUSTIN INC.

MEDICAL HISTORY AND PHYSICAL CONDITION

NAME _____ DATE _____ Signature_____

1. Please list area(s) and reason(s) for physical therapy. _____

_____

2. Have you had physical therapy for this/these problems before? YES NO
If yes, where and when were you treated? _____

_____

3. Have you had surgery related to this/these problems before? YES NO
If yes, what type of surgery did you have and when was the surgery? _____

_____

4. Do you currently have or have you previously had any of the following?

Anxiety/Nervousness	YES	NO	Heart Disease	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO
Asthma	YES	NO	Hernia	YES	NO
Balance problems	YES	NO	High Blood Pressure	YES	NO
Cancer	YES	NO	HIV/AIDS	YES	NO
Circulatory Problems	YES	NO	Kidney Problems	YES	NO
Diabetes	YES	NO	Osteoporosis	YES	NO
Dizzy Spells	YES	NO	Seizures	YES	NO
Headaches	YES	NO	Sensitive to heat/cold	YES	NO
Hearing Problems	YES	NO	Thyroid Problems	YES	NO
Heart Attack	YES	NO	Vision Problems	YES	NO

If yes on any of the above, please explain and give approximate dates. _____

_____

_____

5. Do you currently smoke? YES NO

6. Do you have any allergies, including environmental, lotions/oils, adhesives, and/or medications? YES NO
If yes, please list. _____

_____

7. Do you currently have any metal implants? YES NO

8. Do you currently have a pacemaker? YES NO

9. Do you have any communicable diseases? YES NO

10. Are you currently pregnant? YES NO

11. List any medications you are currently taking. _____

_____

PHYSICAL THERAPY CENTER OF TUSTIN INC.

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FINANCIAL POLICY

Regarding Insurance: You should know that the Physical Therapy services are provided directly to you, and not to an insurance company. Thus, you are ultimately responsible for the bill, not the insurance company. Many people fail to realize that if the insurance company does not pay the bill for any reason, they are still responsible for the bill. It is the person's responsibility to get his or her own claim, our office uses a standardized medical accounting system. The bill you are given, when attached to your insurance claim form, is accepted by the insurance companies as the doctor's portion of the claim form. However, as a courtesy to our patients, we will bill your insurance company for you. It the insurance company has failed to pay within a 90 day period, we will expect you to pay the balance of your bill in full and collect from your insurance company. We will notify you of your responsibility of payment. We ask that you pay on a weekly basis, your last visit of each week.

Special Needs: are understood by us. It may be necessary to set up a payment plan for a patient requiring lengthy treatment. If this situation is necessary for you, please bring the matter up as soon as possible.

AGREEMENT TO PAY

I hereby understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered to me or my dependents and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance as a matter of convenience only and that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me instead of to Physical Therapy Center of Tustin, I will immediately deliver such payment to the above named facility. I understand and agree that if it becomes necessary to commence legal action for the collection of any charges on my account I will be responsible for any cost, fees, or court charges in addition to the outstanding balance.

CONSENT TO TREAT

I hereby consent treatment to myself and/or my dependents, if under the age of 18.

APPOINTMENT CANCELLATION / NO SHOW POLICY

We understand individual schedules may vary and emergencies may occur; however, we appreciate twenty-four (24) hours advanced notice in the event of a cancellation. Failure to do so may result in a **$40** charge. I hereby understand that it is my responsibility to notify Physical Therapy Center of Tustin twenty-four (24) hrs in advance of any change/cancellation of appointment to avoid any cancellation charges.

_____ Patient Initial

_____ Patient Signature

_____ Date

_____ Insured/Parent/Guardian Signature

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PHYSICAL THERAPY CENTER OF TUSTIN, INC.

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NOTICE OF PATIENT INFORMATION PRACTICES

Effective as of April 14, 2003

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

Physical Therapy Center of Tustin's LEGAL DUTY

Physical Therapy Center of Tustin is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Physical Therapy Center of Tustin uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Physical Therapy Center of Tustin may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physical Therapy Center of Tustin may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physical Therapy Center of Tustin's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Physical Therapy Center of Tustin may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of you personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physical Therapy Center of Tustin will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Physical Therapy Center of Tustin may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Physical Therapy Center of Tustin's health information practices or if you have a complaint, please contact the following person:

Taya Sepulveda
Office Administrator
18102 Irvine Blvd. Suite 207
Tustin, CA. 92780

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Physical Therapy Center of Tustin's Notice of Information Practices. I understand that Physical Therapy Center of Tustin may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Physical Therapy Center of Tustin will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy Center of Tustin's notice of information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

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