Orange Coast Orthopedic & Sports Physical Therapy

PATIENT INFORMATION:

FIRST NAME: _____ MI: _____ LAST NAME: _____

D.O.B _____/_____/_____ AGE: _____ MARITAL STATUS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER(S) – HOME: _____ CELL: _____

E-MAIL: _____

WOULD YOU LIKE APPOINTMENT REMINDERS? IF YES, DO YOU PREFER TEXT MESSAGE ☐ OR

BY EMAIL ☐ ? IF BY TEXT, WHAT IS YOUR PHONE CARRIER? _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

REFERRING PHYSICIAN:

_____

PHONE: _____ CITY: _____

EMPLOYER INFORMATION:

ARE YOU CURRENTLY EMPLOYED? YES/ NO (CIRCLE ONE)

FULL TIME/ PART TIME/ MODIFIED DUTY/ OR RETIRED? (CIRCLE ONE)

EMPLOYER: _____ PHONE: _____

ADDRESS: _____

HEALTH INSURANCE:

CARRIER: _____ PHONE: _____

NAME OF INSURED: _____ D.O.B: _____/_____/_____

MEMBER ID: _____ GROUP #: _____

SECONDARY COVERAGE: _____

MEMBER ID: _____ GROUP #: _____

Patient Name: _____

MEDICAL HISTORY FORM

PLEASE DESCRIBE YOUR INJURY OR SURGICAL PROCEDURE PERFORMED:

_____

PLEASE LIST ANY PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

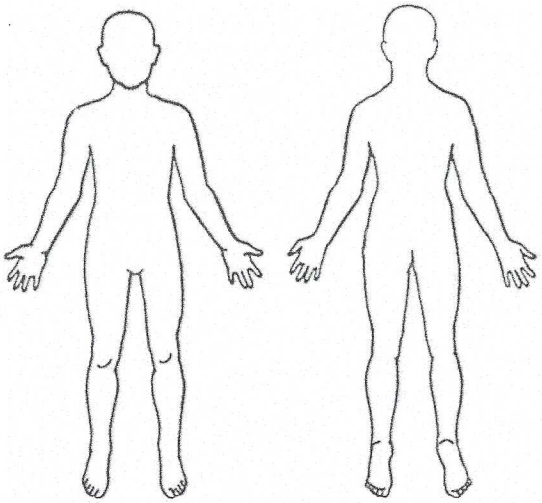
_____

PLEASE LIST ANY SUPPLEMENTS/ VITAMINS THAT YOU ARE CURRENTLY TAKING:

_____

HAVE YOU RECEIVED PHYSICAL THERAPY THIS YEAR FOR ANY INJURY? YES / NO

PLEASE MARK BELOW WHERE YOU CURRENTLY HAVE SYMPTOMS OR PAIN:



FRONT BACK

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

HIGH BLOOD PRESSURE HEART ATTACK HEART DISEASE PACEMAKER SEIZURES HEADACHES CANCER DIABETES HIGH CHOLESTEROL HERNIA KIDNEY PROBLEMS ALLERGIES BLOOD CLOTS DIZZINESS/FAINTING ASTHMA COPD INCONTINENCE LEG OR ARM SWELLING NIGHT PAIN OTHER CONDITION(S) NOT LISTED:_____

Effective: 03/04/2011

FINANCIAL POLICY

Patient Name: _____ Date: _____/ _____/ _____

Welcome to Orange Coast Orthopedic and Sports Physical Therapy! We appreciate the trust you have shown us by choosing us to provide your physical therapy. The service you will receive will most likely come with financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy to you, we will verify your coverage and bill your insurance carrier for those services. However, you are ultimately responsible for payment of your bill.

You are responsible for payment and any co-payments at the time of your service and upon receipt of a bill for any deductible or coinsurance as determined by your coverage provided by your insurance carrier. Many insurance providers have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Orange Coast Orthopedic and Sports Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Orange Coast Orthopedic and Sports Physical Therapy. I agree to pay Orange Coast Orthopedic and Sports Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ Date: _____/ _____/ _____

PRIVACY PRACTICE ACKNOWLEDGMENT

I acknowledge that the Notice of Privacy Practices was given to me and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _____ Date: _____/ _____/ _____

Orange Coast
Orthopedic &
Sports Physical Therapy

NO-SHOW/CANCELLATION POLICY

At Orange Coast Orthopedic and Sports Physical Therapy we want you to get the most out of your physical therapy visits. Your therapist will recommend a specific number of visits per week for your program. A recent study has shown that patients ***who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.*** Even one missed visit can significantly decrease your success and result in a more chronic problem. We **strongly stress the importance of keeping all scheduled appointments** to achieve your personal physical therapy goals.

Helping each and every patient get the results they need is very important. Our schedule is very full and certain time slots are not always available to patients who need them. For this reason, we have a 24-hour cancellation policy in effect. If you cannot make a scheduled appointment, for any reason, we require 24 hours' notice of the cancellation. When you call, we will assist you in rescheduling this appointment because getting your results is our main goal.

Please Read the Following Policy to Better Help Us, Help You.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment that you cannot make with No Less than 24 hours' notice. We will get you rescheduled at that time. If you know you cannot make your appointment and it is after hours, please note that you can still call as we roll our phones every night and will receive your message. Calling after hours and leaving a message the day before is better than calling the morning of your appointment.
3. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
4. While traffic can be unpredictable, we expect that you will call us if you are running late for your scheduled appointment so we can be prepared for your late arrival.
5. Please also be aware that if you are late for your appointment, you are missing the time specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
6. **Please note**, we charge a **$75** missed visit fee for no-shows and cancellations with less than 24 hour notice. This amount is your responsibility as insurance will not cover a missed visit fee. To avoid the **$75** fee, call the office to reschedule an appointment you cannot attend 24 hours in advance.

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

_____ _____ _____

Patient Signature Patient Name Date