THERAPY SPECIALISTS
Care That Delivers.™

Welcome to Therapy Specialists!

The purpose of this letter is to provide you with some helpful information to prepare you for your first visit to the facility.

Prior to your evaluation being scheduled, your primary insurance will be verified and if necessary, authorization obtained. If there is secondary insurance that also will require verification and authorization, it is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding copays, deductibles, referrals, etc. Please remember that benefits quoted are not guarantee of payment per your insurance.

The scheduler will call to schedule the patient's evaluation and subsequent session. At that time, you should have a prescription from your physician to evaluate and treat yourself and/or dependent. Any questions regarding the scheduling of evaluations should be directed to the scheduler.

When you arrive for the evaluation, please come to the Reception Desk in the outpatient area and have with you:

1. The script from your physician to evaluate and treat.
2. Your insurance card.
3. Any co-pays or referrals as required by your insurance company.
4. Copy of driver's license of the parent or legal guardian

Please have all of the above items with you when you arrive or it will be necessary to reschedule your appointment.

After the evaluation has been completed, the therapist will discuss with you a treatment program.

We look forward to seeing you.

Sincerely,

Therapy Specialists' Outpatient Therapy Team

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY AND SIGN BELOW

Name (Last): ____________________ (First):_________________ M.I.:____ Suffix:_____

Home Address: ____

Street address *City* *State* *Zip*

Home Phone: (_____) ______________ **Work Phone:** (_____) ______________

Other Phone: (_____) ______________ **Email:** __________________________________

Social Security #: ___________________ **Birth Date:** ______________ **Age:** ____ **Sex:** M F

Driver's License #: _________________ **Student** (circle one): No Full Time Part-Time

Status: Single Married Divorced Widowed Separated Domestic Partner Minor Child

Emergency Contact: _________________ **Relationship:** ____________ **Ph:** (___)__________

How do you prefer to receive your statements (circle one): Email Fax Mail

Employer: _______________________________ **Occupation:** __________________________

Employment (circle one): Full Part Time Not Working Retired

Address: ____ Ph: (___)______________

Street address *City* *State* *Zip*

Injury Type: Work Auto Home Other _____________ **Date of Injury:** ___________

Attorney Involved: Yes No Attorney Name: _______________________ **P:** (___) __________

Attorney Address: ____ **Fax:** (___) ___________

Street Address *City* *State* *Zip*

Referring Physician (if applicable): ____________________________________ **P:** (___) ___________

Who may we thank for your referral other than your doctor? __________________________________

**Patient Signature: ___________________________________ Date: _________________

All professional services rendered are the ultimate responsibility of the patient.

INSURANCE INFORMATION **(Please Complete)**

Primary Insurance _____________________ Policy # ____________ Effective Dates_____________

Insured Name __________________________ Social Sec # _________________ DOB ______________

Secondary Insurance____________________ Policy # ____________ Effective Dates_____________

Insured Name __________________________ Social Sec # _________________ DOB ______________

Have you applied for Medi-Cal services in the last 6-12 months? Yes No

NOTICE TO CONSUMERS Physical Therapists are licensed and regulated by
The Physical Therapy Board of California (CPTA).
Ph. (916) 561-8200 www.ptb.ca.gov

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MEDICAL HISTORY

Patient Name: ____ Age: _________________

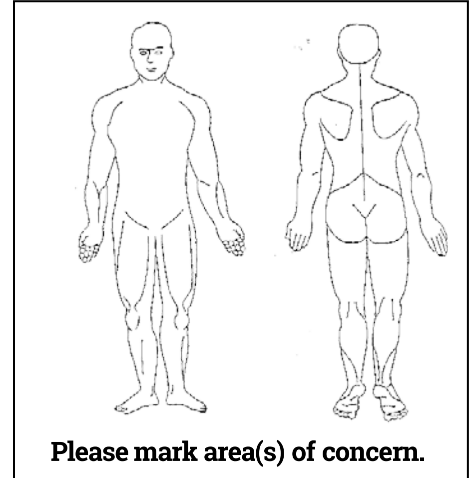
Type of Injury/Condition: _______________________________ Onset/Injury Date: _________

Type of Surgery and Date: _______________________________

Next Doctor's Appointment? ______________________________

Describe previous treatment for this condition: _______________

____



Please mark area(s) of concern.

Have you received physical therapy this year? Yes / No

Have you received speech therapy this year? Yes / No

Have you received Home Health Care via Medicare this year?

Yes / No

Have you had any imaging performed?

X-ray MRI CT Scan Doppler Ultrasound

Have you recently noted?

Weigh Loss/Gain Weakness Pregnant/IUD Pain at Night ☐ Nausea/

Fever/Chills/Sweat Headaches Cramps in legs when walking Vomiting Fatigue

Numbness/Tingling Change in Vision or Hearing Insomnia

Do you have now or have you ever had any of the following?

Surgeries Sprains/Strains Heart Problems Circulation Problems/Clots

Easy Bruising/Bleeding Indigestion/Heartburn Loss of Consciousness

Diabetes Cancer Asthma/Breathing Problems Leg/Ankle Swelling

Fainting Fractures Blood Pressure Problems Motor Vehicle Accident Allergies / Skin Sensitivity

Lung Disease Urinary Problems/Infections

Any previous injury that may affect current care ____

Explain & give approximate dates for any items indicated above

Are you currently taking medications?? ☐ Yes ☐ No Name or Type of Medication _____________

____

Type of Pain: Sharp Burning Aching Tingling Numbness Other: ___________

Rate your pain (1=minimal; 10=severe): At its worst: ______ At its best: ______

What do you hope to get out of your treatment? ____

____

What are your physical fitness goals? ____

____

Is there anything else you would like to include or ask your physical therapist?

____

____ _____________________________

Patient or Personal Representative Signature Date

Office Policy

Consent for Care and Treatment: Your physical therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I do hereby agree and give my consent for Therapy Specialists to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply.

I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

Signature ____ Date: ____________________

Consent for Treatment of a Minor: I, the undersigned, do agree to give my consent for the minor patient's condition. As parent and/or legal guardian, I authorize Therapy Specialists to supply information to insurance carriers concerning this treatment and I hereby assign all payment for ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Therapy Specialists to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature ____________________________________ Date: ____________________

Assignment of Insurance Benefits: I hereby authorize Therapy Specialists to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Workers Compensation Claims: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Cancellation and No-Show Policy: We require 24 hours' notice in the event of a cancellation. The charge for cancellation without proper notice is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Financial Policy: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full form you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. 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. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $ ____________________

Arrangements for payment of patient's co-pay/deductible (circle one):
○ WILL PAY EACH VISIT ○ WILL PAY WEEKLY IN ADVANCE

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ ____________________
Patient/Guardian/Responsible Party Date

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Appointment Reminder Consent Form

Patient Name: ____
Please complete this form and sign below to give your permission for Therapy Specialists to provide automatic appointment reminder service by email or by textmessage.

Please Print Clearly

Step one: Select most preferable option below:

Therapy Specialists may send email messages to confirm my upcoming appointments to the following email address: ____

Therapy Specialists may send a text message to confirm my appointments to this cell number: ____

Step Two: If you would like text messages instead of email reminders, please indicate your cell phone carrier.**

**We cannot set your account up to send text reminders without knowing your cell phone carrier. Please indicate your carrier below if you would like text reminders. Thank you!

Alltell
AT&T
Boost Mobile
Cingular
Cricket Wireless
Metrocall
MetroPCS
Nextel
Qwest
Sprint PCS
T Mobile
US Cellular
Verizon
Virgin Mobile
Decline

____ ________________
Signature of Patient or Guardian Date

Patient Name (Print):____

By my signature I acknowledge receipt of the Therapy Specialists notice of privacy practices.

____ ________________
Signature of Patient/Responsible Party Date