GARDENA PHYSICAL THERAPY AND REHABILITATION CENTER
1045 W REDONDO BEACH BLVD., #130 Gardena, CA. 90247 (310) 329-1444

Date:__________________ Attending Dr: __________________
Referred By: __________________ Dr's Phone #:_______________

Your Name:___________________________ M/F DOB:______________ Age:________
Address:_________________________apt___ City:_______________ State:______ Zip:________
Home Phone:__________________ Work Phone: ________________ Cell Phone:______________
SSN:_______-_____-_________ Drivers License:_________________ Email:________________
Date of Injury/accident/symptoms occurred:________________Married/Single/Widowed/Divorced
Area to be treated:____

EMPLOYEMENT INFORMATION
Current Employer:______________________________ Phone #:________________
Address:_____________________________ City:_________________ State:_________ Zip:_________
Occupational Title:_______________________________ How Long Employed?:________________

PRIVATE HEALTH INSURANCE
Insurance Company Name:______________________________ Phone #:________________
Claims Address:_______________________ City:_________________ State:________ Zip:_________
Name of Insured:_______________________________ Insured DOB:________________
Relationship of Insured:___________________ Policy #:___________________ Group#:____________

IN CASE OF EMERGENCY
Relative / Local Friend: ____________________________ Relationship: __________________
Address:____ Phone #:_____________________
Patient Signature:______________________________________Date:____________________________

If we are treating you due to a work, auto or personal injury please complete the appropriate sections below

WORKERS COMPENSATION INFORMATION (If this is a work related injury complete this section)
Employer at the time of injury: ________________________________ Phone #:________________
Address:__________________________ City:_________________ State:_________ Zip:___________
Workers Comp Insurance Carrier:______________________________ Phone #:________________
Claims Address:_______________________ City:_________________ State:________ Zip:_________
Adjuster:__________________________________ Phone #:________________ Ext#:__________
Claim #:__________________________________ WCAB#:____________________________

ATTORNEY INFORMATION
Attorney Name: ________________________________ Phone #:___________________
Address:__________________________ City:_________________ State:________ Zip:_________

PERSONAL INJURY INFORMATION
Insurance Company Name: ________________________________ Phone #:___________________
Address:__________________________ City:_________________ State:_________ Zip:_________
Contact Person:__________________________ Policy #:______________ Group #:________________
Med Pay Coverage: Yes / No If yes, how much?_____________ Name of Defendant:________________
Defendants Insurance Company:_________________________________ Phone #:________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY

I hereby authorize Gardena Physical Therapy & Rehabilitation Center/ Jana VanSurksum P.T., to furnish information to insurance carriers and/or referring or family physicians concerning my condition and treatments rendered. I hereby authorize payment directly to the above named of the insurance benefits otherwise payable to me. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

Gardena Physical Therapy
Patient Information Consent Form

I have read and fully understand Gardena Physical therapy's Notice of Information Practices. I understand that Gardena Physical therapy 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 Gardena PT 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 Gardena Physical therapy'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 Patient Signature

____

Date

I also authorize Gardena Physical therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

____________________________ ____________________________

Patient Name Patient Signature

____

Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. (spouse, relative, or friend)

Authorized Designees:

Name:________________________ Relationship:________________

Name:________________________ Relationship:________________

____________________________ ____________________________

Patient Name Patient Signature Date

GARDENA PHYSICAL THERAPY

1045 W. Redondo Beach Blvd., Suite 130,
Gardena, CA 90247
(310) 329-1444 Fax (310) 329-9586

Financial Policy

CONSENT FOR CARE & 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 the undersigned do hereby agree and give my consent for Gardena Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Gardena Physical Therapy 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.

HMO CLAIMS: I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is that listed on my authorization. I am aware that if the above is not true or changes during treatment, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if my IPA/Medical Group changes and I do not have a current authorization with your office I (or the person financially responsible for me), will pay in full all such charges.

CANCELLATION & NO SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for your first cancellation or no show without proper notice is $25. The fee for any occurrence thereafter will be $40. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. We understand that emergencies may occur, in the event you have an emergency please contact the office.

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 at each visit. If your insurance carrier does not remit payment to us within 60 days, the balance owed may be due in full from you. 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 payments to us. If formal collection procedures become necessary you will be responsible for additional costs incurred. A return check fee of 25.00 will be assessed if your check is returned. Your insurance benefits as quoted to us by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. All co-pays are due prior to each physical therapy treatment. Any unpaid balance over 60 days can be referred to collections and will incur a $10 fee. Any personal requests for records will be charged a fee. The fee for records starts at $15.00 and is based on the size of your chart.
We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible. Any changes made to your insurance plan, medical group and doctor must be communicated to us in writing prior to services rendered. Any denial of services due to changes made after the start of service will be patient responsibility.

CONSENT FOR TREATMENT OF A MINOR: *As parent and/or legal guardian, I authorize Gardena Physical Therapy to treat the minor patient named in the attached forms while I am not present.*

Your insurance has quoted us the following benefits. This is not a guarantee of coverage and you should contact your insurance for detailed benefits.

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

____

Patient Name (print) ***Date***

____

Signature of Patient / Guardian/ Responsibility Party ***Relationship*** ***Date***

A SPECIAL WORD TO OUR PATIENT'S
ABOUT YOUR RESERVATION TIME WITH US

The unique quality of our firm is shown by the high level of professional care provided to each of our patients. Because health care is expensive and quality care should not be compromised, we provide hands-on, direct professional care from a licensed Physical Therapist and licensed Physical Therapist Assistant. Your appointment is really a reservation. We believe, on faith, that if a patient says they are going to arrive for a reservation that they will be here at our office on time. This means that we will hold your reservation especially for you and not give it to any other patient. If you miss your reservation, we still have to pay our professional staff who was available for you.

Please understand our policy related to your reservation:

1. There will be no penalty for patients who cancel their reservation twenty-four (24) hours in advance. Thank you for your courtesy. We will reschedule you for another date. We understand that emergencies occur. First time emergencies will not apply to this policy. If a patient has multiple emergencies then this policy will apply.

2. **If you cancel your reservation with less than twenty-four (24) hours notice to us you will be charged $25 for your first missed reservation time and $40.00 each additional missed reservation.** Remember, our costs continue, whether or not you are treated. If we do not have the opportunity to treat you, then we cannot bill your insurance. Understand, please, that charges for missed reservations are never covered by any type of insurance coverage, and these expenses will be directly out of your pocket.

3. If you have been injured on the job and/or are sponsored by Worker's Compensation Insurance, be aware that we are obligated to notify your insurance company and your physician when you miss a physical therapy reservation without proper notice.

We really do not want to apply any of the regulations found in this letter. Our goal is to achieve for you the highest quality of care in an efficient and timely manner. We hope you understand our position in these sensitive matters and we look forward to working with you.

________________________ ______________________________

Patient Name Signature

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Date