SKYPARK
Physical Therapy

PATIENT INFORMATION

Full Name: _____ Gender: ☐Male☐Female D.O.B: ____/____/____
Address: _____
Home #: _____ Mobile #: _____ Work #: _____
Email: _____ Employer & Occupation: _____
Work Address: _____
Driver's License (REQUIRED): _____ S.S.N (REQUIRED): _____
Emergency Contact Name (Relation) & Phone #: _____
Friend/Relative (NOT living with you) Name & Phone #: _____
Referred by (physician, friend, etc.): _____ Phone #: _____

BILLING & INSURANCE

Name of Insured: _____ Date of Injury/Onset: _____/_____/_____
Reason for Referral: _____
_____
Please check which insurance applies: ☐Medicare ☐W/C ☐Private ☐Cash ☐Other
Insured Party: ☐Self ☐Spouse ☐Other Condition: ☐Work ☐Auto ☐Other
Please provide insurance information of ALL applicable policies that may cover services while under our care:
Insurance (1): _____ Group/Policy #: _____
ID #: _____ Claim #: _____
Contact #: _____ Adjuster: _____

(REQUIRED) PLEASE SUBMIT YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE FOR PHOTOCOPY TO MAINTAIN IN YOUR MEDICAL RECORDS

For patient's with attorney representation/personal injury
Attorney: _____ Phone: _____
Contact: _____ Fax: _____

ACCOUNTABILITY

My signature below certifies the information contained herein as correct and true. I understand that I am ultimately financially responsible for services provided regardless of insurance payment or legal representation. As designated legal guardian for this patient, my signature authorizes treatment for this minor.

PATIENT'S RIGHTS

I understand that I have the right to:

- Respectful and courteous care regardless of race, religion, gender, nationality, orientation, age, or disability
- Participate in my healthcare treatment plan
- Continue to self-pay for services after insurance benefits have ceased
- Be informed of risks/benefits of treatment and alternatives
- Choose my own therapist and know their qualification
- Grant/deny access of my confidential medical records to other persons or agencies

X _____
Patient/Guardian Signature

X _____
Date

23332 Hawthorne Blvd, Suite 202
Torrance, CA 90505

Phone: (310)-373-5288
WWW.SKYPARKREHAB.COM

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MEDICAL HISTORY

Please provide your detailed medical history by filling out this form. This is a REQUIREMENT by Medicare for us to keep a detailed record of your health history.

Name: _____ Date: _____

Personal History:

Heart Disease	☐Yes☐No	Pregnant	☐Yes☐No	Osteoporosis	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Heart Attack	☐Yes☐No	Diabetes	☐Yes☐No	Tuberculosis	☐Yes☐No	Thyroid Dysfunction	☐Yes☐No
Hernia	☐Yes☐No	Cancer	☐Yes☐No	Asthma	☐Yes☐No	Congenital Abnormalities	☐Yes☐No
High BP	☐Yes☐No	Pacemaker	☐Yes☐No	Hepatitis	☐Yes☐No	Surgical Implants	☐Yes☐No
Stroke	☐Yes☐No	Pneumonia	☐Yes☐No	Anemia	☐Yes☐No	Respiratory Disease	☐Yes☐No
Epilepsy	☐Yes☐No	Emphysema	☐Yes☐No	Bleeding Disorder	☐Yes☐No	Kidney/Bladder Dysfunction	☐Yes☐No

Please list all surgeries, invasive medical procedures, fractures, and other serious injuries. Include approximate date and any lasting complications/disabilities: _____

_____

_____

Please list present medications that you are taking: _____

_____

_____

Do you have any allergies to the following?

Novocaine/Lidocaine ☐Yes☐No Iodine Compounds ☐Yes☐No Latex ☐Yes☐No Height: _____ Weight: _____

Other: _____ Alcohol Use: ☐Yes☐No If yes, how much? _____ Smoke: ☐Yes☐No If yes, how much? _____

Family History - Has any immediate family relative ever had any of the following:

Heart Disease	☐Yes☐No	Stroke	☐Yes☐No	Bladder Dysfunction	☐Yes☐No
Heart Attack	☐Yes☐No	Epilepsy	☐Yes☐No	Diabetes	☐Yes☐No
Rheumatic Fever	☐Yes☐No	Kidney Dysfunction	☐Yes☐No	Cancer	☐Yes☐No

I certify that this information is correct and true.

X _____ X _____

Patient's Signature Date

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FINANCIAL POLICY

Please read and sign our financial policy then check, sign, and date the bottom statement. Your signature is required BEFORE rehabilitatio services can be provided at our facility.

Check insurance/payment type that applies to you:

☐**Medicare**: Our facility accepts Medicare reimbursement for rehabilitation services. Payment from Medicare only covers approximately 80% of rehabilitation services, therefore your secondary insurance (medi-gap) is responsible for the remaining 20%. Our facility CANNOT bill fo additional expenses/charges not covered by Medicare/secondary policies and must accept reimbursement as payment in full.

Some exceptions include:

- If you have not met your annual $183.00 deductible, you are rightfully responsible to pay this amount.
- Your secondary insurance has a deductible, or limited reimbursement, which requires you to pay the remaining applicable balance.
- Our office will notify when you reach the number of visits allowed per your diagnosis.
- You desire to continue treatment after benefits have ceased, therefore you may elect to self-pay (i.e. cash, check, card).
- If you used physical/speech therapy services within the last calendar year, treatment at this facility may reach the Medicare cap earlier thai expected which could result on Medicare denial and issue a bill to the patient.
  ***Note: **Speech and Physical Therapy benefits are combined and Medicare allows for a set $ amount per year for these services**
- You were involved in litigation (i.e. car accident, slip and fall) for which liability insurance should cover medical care primarily. If this information was not disclosed and settlement was made, you may be required to reimburse Medicare for any payment made to our facility.
- If you do not have a secondary insurance, you will be billed the 20% Medicare allowed.

☐**Private Insurance**: ***As a courtesy to our patients, we will bill your insurance company for you and withhold action for 45 days. If you insurance has failed to pay within 45 days we will expect you to pay your bill in full and seek reimbursement from your insurance.*** We wil also assist you in verifying your insurance benefits. Any remaining balance, co-pay, delinquent payment or deductible amounts due for service rendered are your responsibility. ***Co-payments are due at the time of visit.*** Delinquent, late or overdue balance amounts may accrue interest. **I you are unable to keep your appointment, please provide a 24-hour cancellation notice. If you do not, you will be charged $25.00 fo cancelling less than 24 hours and $50.00 if you do not cancel at all.**

☐**Cash**: Our facility will accommodate check/credit card payment plans in the event of non-payment from insurers, out-of-network plans, o non-coverage of rehabilitation services. I agree to pay $_____ **INITIAL HERE** _____

☐**Liens**: We will accept lien agreements provided that an attorney represents you. Both YOU and your ATTORNEY are required to sign a lie document. In the event of a discontinued litigation case, or if you are not successful in winning your litigation, you are ultimately financiall RESPONSIBLE for services rendered. ***Please sign and attach a lien document form to this file.*** **If you are unable to keep your appointment please provide a 24-hour cancellation notice. If you do not, you will be charged $25.00 for cancelling less than 24 hours and $50.00 if yo do not cancel at all.**

☐**Worker's Compensation**: As a courtesy to our patients we will bill your insurance and withhold action within 45 days. If you are covere (authorized by your employer Worker's Compensation benefits, you are not liable for any additional payments. **If you are unable to keep you appointment, please provide a 24-hour cancellation notice.**

☐**Worker's Compensation Liens**: We will accept liens agreements providing you sign a lien document. If you have filed a fraudulent claim and no payment settlement is made, there you are ultimately financially RESPONSIBLE for services rendered. If you are unable to keep you appointment, please provide a 24-hour cancellation notice.

AUTHORIZATION TO RELEASE RECORD: I hereby authorize Skypark Physical Therapy to release my medical records to my attorney my insurance company or Skypark Physical Therapy representative for collection and also to myself upon my request.

I HAVE READ AND FULLY AGREE TO THIS INFORMATION PRESENTED.

X_____ X_____

Patient's Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be disclosed/used and how you can access this information. PLEASE REVIEW IT CAREFULLY.

- At Skypark Physical Therapy, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give this notice, and to follow the terms of this notice.
- This law permits us to disclose/use your health information to those involved in your treatment. For example, a review of your file may be given to a specialist doctor whom we may involve in your care.
- We may disclose/use your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may disclose/use your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information.
- We may also want to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not disclose/use your health information without your prior written authorization.
- You may request in writing that we not disclose/use your health information as described above.
- We will notify you if we can fulfill your request. You have the right to know of any disclosures/uses we make with our health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whichever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Provide us with a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Provide us, in writing, your request to make changes and include a statement (if necessary). We may or may not make the changes you request but will be happy to include your statement in your files. If we agree to an amendment/change, we will not remove/alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details in this notice, we will notify you of the changes in writing.

You may file a complaint with the **Department of Health and Human Services 200 Independence Avenue, S.W., Room 509F, Washington DC 20201.** You will not be retaliated against for filing a complaint. Before filing a complaint, please contact our office for more information or assistance regarding your health information privacy at (310)-373-5288.

Acknowledgement - I have received a copy of the Skypark Physical Therapy Notice of Privacy Practice.

_____
Print Name (If signing as a parent/guardian, please note the name of the patient)

X_____
Patient's Signature

X_____
Date

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WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN
ID OR CASE #: _____

Injured Worker: _____ Date of Birth: _____/_____/_____

Address: _____

Social Security #: _____ Date of Claimed Injury: _____/_____/_____

Attorney of Injured Worker: _____

Attorney Address: _____

Employer & Address: _____

Insurance Carrier/Self Insured Certificate Name: _____

Address Where Claim Was Administered: _____

_____

Adjusting Agency (if agency administered): _____

Attorney for Employer/Carrier: _____

Attorney for Employer/Carrier Address: _____

_____

Lien Claimant: _____ Contact #: _____

Lien Claimant Address: _____

Attorney for Lien Claimant: _____ Contact #: _____

Attorney for Lien Address: _____

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The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ ($_____) against any amount now due of which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (check ONE appropriate box):

☐The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relive from the effect of said injury

☐The reasonable medical expense incurred to prove a contested claim

☐The reasonable value of living expenses of said worker or of his / her dependents, subsequent to the injury

☐The reasonable living expenses of the spouse, minor children, or both of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his / her family

☐The reasonable fee for interpreter's services performed on (date) _____

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

For injuries occurring ON / AFTER January 1, 1990 FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

☐A copy of the original completed Employee's Claim for Worker's Compensation Benefits (DWC Form 1) is attached or

☐The lien claimant does not have a copy of the claim form, but made the following efforts to secure one

☐A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties

X_____
Signature of Attorney for Lien Claimant

X_____
Signature of Lien Claimant

X_____
Date

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I CONSENT TO THE REQUESTED ALLOWANCE OF A LIEN AGAINST MY COMPENSATION.

X_____
Signature of Attorney for Injured Worker

X_____
Signature of Injured Worker

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SKYPARK PHYSICAL THERAPY MISSED APPOINTMENT POLICY

If you are represented by an attorney and miss 2 appointments in a row, it is SKYPARK PHYSICAL THERAPY'S policy to contact your attorney and physician's office.

In order to OPTIMIZE your rehabilitation, it is important for you to be CONSISTENT with your appointments.

Thank you for your cooperation.

X_____
Patient's Signature

X_____
Date

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the RIGHT TO REQUEST a restriction on used and disclosures o their protected health information (PHI). The individual is also provided the RIGHT TO REQUEST confidentia communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____ MD: _____

Diagnosis: _____ MRN: _____

I wish to be contacted in the following manner (Please check all that apply):

Voice Communication

Home #: _____ Cell/Text #: _____ Work #: _____

☐Leave a message with DETAILED information: ☐Home ☐Cell/Text ☐Work

☐Leave a message with ONLY call back number: ☐Home ☐Cell/Text ☐Work

The following individuals are AUTHORIZED to receive my medical information:

Name: _____ Contact #: _____ Relationship: _____

Name: _____ Contact #: _____ Relationship: _____

Name: _____ Contact #: _____ Relationship: _____

Written Communication

Mail To Home Address: _____

Mail To Work Address: _____

Home Fax: _____ Work Fax: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses/disclosures made pursuant to an authorization requested by an individual. Healthcare entities must keep records of PHI disclosures.

I have received Skypark Physical Therapy Notice of Privacy that provides a more complete description of information uses / disclosures. I understand that it may become necessary to disclose my PHI to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the Notice of Privacies Policies. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile, and mail.

I understand that I may request restrictions regarding the use of my health information to revoke this consent by following procedures outlined in the Notice of Privacy Policies. However, Skypark Physical Therapy is NOT required to agree with any restrictions that I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

NOTE: Uses/disclosure for treatment, payment, and operations (TPO) information may be permitted WITHOUT prior consent in an emergency.

X _____ X _____

Patient/Guardian Signature Date

X _____ X _____

Print Name Name of Patient (if different)

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