

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



FINANCIAL POLICY

Please read and sign our financial policy then check, sign, and date the bottom statement. Your signature is required BEFORE rehabilitation 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 for 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 than 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 your 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 will also assist you in verifying your insurance benefits. Any remaining balance, co-pay, delinquent payment or deductible amounts due for services rendered are your responsibility. **Co-payments are due at the time of visit.** Delinquent, late or overdue balance amounts may accrue interest. **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 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, or 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 lien document. In the event of a discontinued litigation case, or if you are not successful in winning your litigation, you are ultimately financially 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 you 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 covered (authorized by your employer Worker's Compensation benefits, you are not liable for any additional payments. **If you are unable to keep your 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 your 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 _____
Patient's Signature

X _____
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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SKYPARK

Physical Therapy

To: Attorney _____ Re: _____
D/I: _____

Re: Authorization and Agreement to Pay Medical Fees

I do hereby AUTHORIZE the above Physical Therapy Clinic to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby AUTHORIZE and DIRECT you, my attorney, to pay directly to the mentioned Physical Therapy Clinic from my portion of the proceeds of any recovery which may be paid to me through my attorney, such sums that may be due and owing for medical services rendered and to be rendered me by reason of this accident, as well as for consultations, depositions, and court appearances on my behalf.

I fully understand that I am directly and fully responsible to the mentioned Physical Therapy Clinic for all medical bills submitted, for services rendered and to be rendered to me, and I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover the said fee. In the event that the below signed attorney withdraws, substitutes out of the case or changes, I and the signed below attorney each agree to give notice of such event within 30 days from the date of the event. I further agree to instruct any attorney retained by me execute and honor this lien.

I and the below signed attorney agree that the Clinic will be notified of any recovery within 30 days from receipt thereof and the amount determined to be outstanding must be paid within 45 days from receipt thereof. This agreement shall be binding on the successors, heirs, and assigns of the ones who signed below. Those whom have signed below further agree that in any action / proceeding to enforce this agreement, the prevailing party will be entitled to recover reasonable attorney's fees and cost.

X

Patient's Signature

X

Date

The under signed, being attorney of record for the ABOVE patient does hereby agree to observe and to be bound by all terms of the above settlement, judgment, or verdict as may be necessary to adequately protect the said above named.

X

Attorney's Signature

X

Date





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





PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the RIGHT TO REQUEST a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the RIGHT TO REQUEST confidential 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

Patient/Guardian Signature

X

Date

X

Print Name

X

Name of Patient (if different)

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