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

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

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 _____
Patient's Signature

X _____
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 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 _____ X _____
Patient's Signature Date

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MEDICARE SECONDARY PAYER SCREENING FORM

1. Are you currently working full or part-time? ☐Yes ☐No If yes, what is your retirement date? _____

2. Are you married? ☐Yes ☐No If yes, is your spouse currently working full or part time? ☐Yes ☐No

   What is his/her retirement date? _____

3. Are you covered under an employer group health plan based on your or your spouse's current employment?

   ☐Yes ☐No If yes, please provide the following:

   Name of insured: _____ Relationship: _____

   Name of employer: _____ Group I.D. #: _____

   Name and address of insurance company: _____

   _____

   Policy #: _____

4. Are you entitled to Black Lung Medical Benefits? ☐Yes ☐No

5. Is this service for treatment of a work-related injury/illness? ☐Yes ☐No If yes, please provide the following:

   Name of employer: _____

   Name and address of W.C. insurance: _____

   _____

   Claim #: _____

6. Is this service for treatment of an injury/illness that resulted from an automobile accident? ☐Yes ☐No

   If yes, please provide the following:

   Name of insured: _____ Claim/Policy #: _____

   Name and address of insurance company: _____

   _____

7. Are these services to be paid by a program such as a government research grant?

8. Have you received a kidney transplant? ☐Yes ☐No If yes, what date did you receive it? _____

9. Have you received dialysis treatments? ☐Yes ☐No If yes, what date did it begin? _____

Please be advised, the patient MUST complete all of the above questions. This is a requirement of MEDICARE and if you have any questions, please contact the Social Security Administration.

X _____
Patient's Signature

X _____
Date

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Physical Therapy

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient Name: _____ I.D. #: _____

NOTE: If Medicare DOESN'T pay for Physical Therapy Services below, you may have to pay. Medicare does not pay for everything even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the treatment below

Physical Therapy	Reason Medicare May Not Pay	Full Estimated Costs
Physical Therapy Services denied due to Home Health Episodes	Services that exceed the cap limitations of $2,040 per calendar year Number of services exceed the norm and no medical necessity demonstrated for the extra number of services Medicare does not cover Home Health Services in conjunction with outside Physical Therapy Services	Initial Evaluation - $150 Follow Up Visits - $75

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an OPTION below about whether to receive the **Physical Therapy Services** listed above
- NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare CANNOT require us to do this.

OPTIONS: Check only ONE box. (We CANNOT choose for you)

☐**Option 1**: I want the Physical Therapy Services listed above. Please first bill Medicare, and I can appeal to Medicare if their offered decision is "non-payment".

☐**Option 2**: I want the Physical Therapy Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I CANNOT appeal if Medicare is not billed**.

☐**Option 3**: I don't want the Physical Therapy Services listed above. I understand with this choice I am NOT responsible for payment and **I CANNOT appeal to see if Medicare would pay**.

Additional Information: **This notice gives our opinion, not an official Medicare decision**. If you have other questions on this notice or Medicare billing, call (800)-633-4227 (TTY: (877)-486-2048). Signing below mean that you have received and understand this notice and that you also received a copy.

X _____ X _____
Patient's Signature Date

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call (800)-633-4227 or email: AltFormatRequest@cms.hhs.gov

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resource, gather the data needed, and complete / review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write: CMS, 7500 Security Blvd, Attn: PRA Reports Clearance Officer. Baltimore, Maryland 21244-1850.

SKYPARK
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ASSIGNMENT FOR DIRECT PAYMENT

I hereby AUTHORIZE payment by check, made out directly to:

Skypark Physical Therapy & Rehabilitation
23332 Hawthorne Blvd, Suite 202
Torrance, CA 90505
Phone: (310)-373-5288

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for professional services rendered by Skypark Physical Therapy. The payment WILL NOT exceed my indebtedness to the above mentioned assigned and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, then I hereby also instruct you to make out the check to me, and mail it to me in care of Skypark Physical Therapy.

A photocopy of this assignment shall be considered as EFFECTIVE and VALID as the original.

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 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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