OrthoSport OC Physical Therapy
Patient Registration

26522 La Alameda Suite 100
Mission Viejo, CA 92691

Patient Information

Patient Name ____
Last First Middle Initial

What is your preferred method for appointment reminders? ☐ Voice call ☐ Text message ☐ Email ☐ Written card

Occupation ______________________ Employer ______________________

Who may we thank for referring you? ______________________

Responsible Party

☐ Self (IF SELF, GO TO NEXT SECTION) ☐ Parent ☐ Spouse Date of Birth __________ SS#/DL# ______________

Parent or Spouse's Name ______________________ Phone Number ______________

Address ______________________ City ______________________ State ________ Zip Code __________

Accident Information

Motor Vehicle Accident? Yes No State in which accident happened __________ Date of Accident ______________

Work Related Injury? Yes No Adjuster ______________ Claim # ______________ Phone ______________

Attorney Involved? Yes No Name ______________________ Phone ______________

Insurance Information

I am not using HMO benefits __________
Initial

Do you have a secondary insurance? Yes No If yes; Ins Name ______________ ID# ______________ Phone ______________

Assignment of Benefits / Release of Information

I hereby authorize payment to OrthoSport Physical Therapy for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due. I authorize the release of any medical information necessary to process claims.

______________________ ______________ ______________________
Signature Relationship Date

OrthoSport OC Physical Therapy
Medical Screening

This Questionnaire Is Designed to Enable Us To Assess Your Medical History

Date ____________ Name ______________________ Age ___ Sex M F Height_______ Weight ______

What part of your body is presently injured? ____

When did it occur/begin? ____

How did it occur? ____

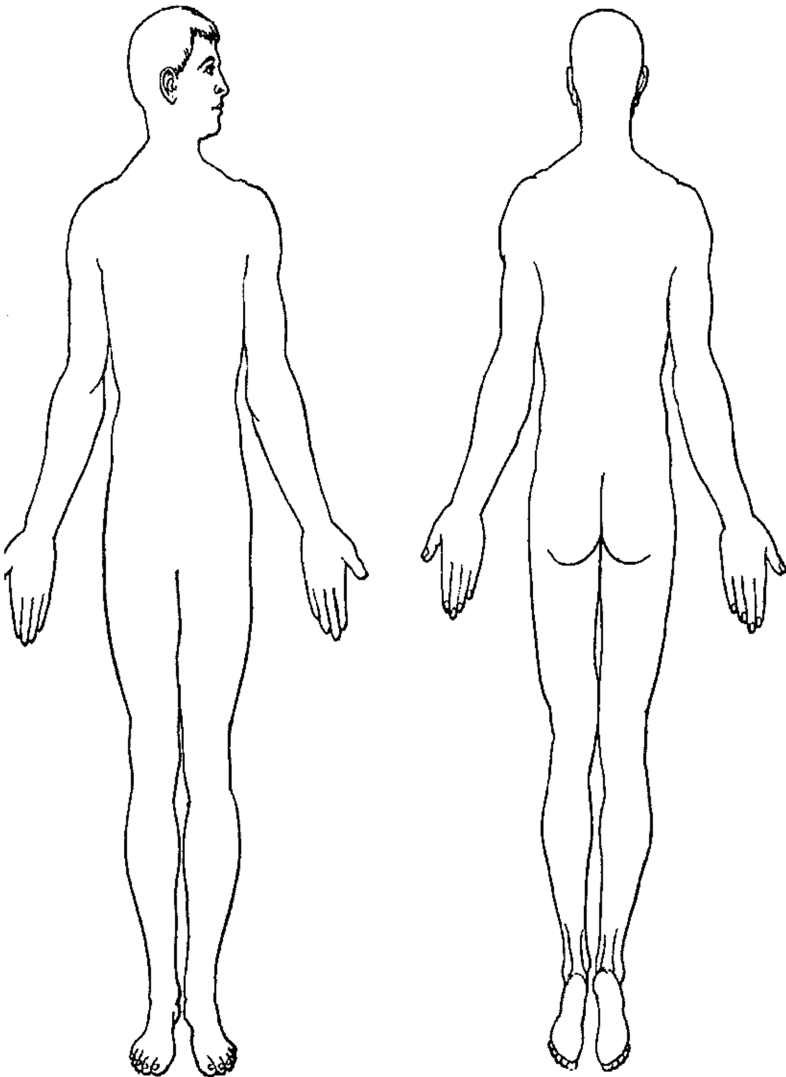
____

Is this from an auto accident within the last 90 days? Y / N When? __________ Did you have surgery for this problem? Y / N When? ____________________ Where? _____________By whom? ______________

Have you ALREADY received any treatment such as P.T., chiropractic or acupuncture for this particular injury? Y / N

What type and when? ____

Please use this picture to tell us more about your symptoms:



Numbness = = = = Pins & Needles o o o o Burning x x x x Stabbing / / / / Aching (((

(Feel free to add any other descriptors as needed)

Therapist's Notes (please leave blank)

OrthoSport OC Physical Therapy
Medical Screening

Are your symptoms?

□ Getting Worse □ Staying the same

□ Improving

How are you able to sleep at night?

□ Fine □ Moderate Difficulty

□ Only with medication □ The pain wakes me at night

Do you have any problems with?

□ Hearing □ Vision □ Speech □ None

Have you had any RECENT illnesses/infections?

□ Yes □ No If yes, what? ________________

Do you or have you smoked tobacco?

□ Yes □ No If yes, ____ packs / day x ____ years

Do you drink alcoholic beverages?

□ Yes □ No If yes, ______drinks / week

Date of last general physical exam: ___________

List any medications you are currently taking and why: ____

____

____

____

____

Have you or any immediate family member ever been told you have?

	Self	Family
Cancer	yes no	yes no
Diabetes	yes no	yes no
Hypertension	yes no	yes no
Heart disease	yes no	yes no
Chest pain	yes no	yes no
Stroke	yes no	yes no
Osteoporosis	yes no	yes no
Osteoarthritis	yes no	yes no
Auto Immune	yes no	yes no
Anemia	yes no	yes no
Bleeding disorder	yes no	yes no
Blood Clot	yes no	yes no
Tape / Latex allergy	yes no	yes no

Are you CURRENTLY experiencing?

Persistent, unrelenting pain	yes no
Excessive fatigue	yes no
Nausea/vomiting	yes no
Fever/chills/sweats	yes no
Unexplained weight change	yes no
Numbness or tingling	yes no
Changes in appetite	yes no
Difficulty swallowing	yes no
Bowel / bladder dysfunction	yes no
Shortness of breath	yes no
Dizziness	yes no
Pregnancy	yes no
Depression	yes no
Abnormally high stress	yes no

***If you are experiencing any other unusual symptoms or have any other medical condition not listed, please inform your physical therapist or list here** ____

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No one under the influence of drugs or alcohol may participate in physical therapy at any time

I will advise my therapist if there is a change in my physical condition which would alter my response to any questions on this form.

Signature of Patient ______________________________ Date ______________

OrthoSport OC Physical Therapy
Financial and Office Policy

-This is an agreement between OrthoSport OC Physical Therapy, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to OrthoSport OC Physical Therapy.
By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Payment arrangement if you have no insurance: You will need to pay by cash, check or credit card on the day the treatment is rendered.

Payment options if you have insurance: You are responsible for your deductible and any out of pocket portions at the time services are rendered. If your deductible due exceeds $400 you are subject to our deductible policy.

Deductible Policy: If your deductible due exceeds $400 you will need to pay TBD cash amount for the first visit and TBD cash amount thereafter until your deductible is met. This amount is a good faith payment which will be applied TOWARD your total deductible balance. You will receive a bill for the remaining amount.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days. The **FINANCE CHARGE** will be computed at the rate of (.83%) per month or an **ANNUAL PERCENTAGE RATE** of (9.96%) percent. The finance charge on your account is computed by applying the periodic rate (.83%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Any discounts offered must be paid at the time of service. We cannot bill you at a discounted rate.

Returned checks: There is a fee (currently $30) for any checks returned by the bank.

Missed appointment fee: The second time a patients does not show up on time for an appointment, or cancels with less than 24 hours notice, a $25 fee will be charged. Patients with three missed appointments will be taken off the schedule and asked to call the day of for appointments.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records or have them sent to another doctor or organization. The amount of the fee is dependent upon the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.
Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.
Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

OrthoSport OC Physical Therapy
Financial and Office Policy

IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1) If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:

   a) Do not write on the bill. On a separate sheet of paper write (you may telephone your inquiry but *doing so will not preserve your rights under this law*) the following

      i) Your name and account number.

      ii) A description of the error and an explanation (to the extent you can explain) why you believe it is an error.
      If you only need more information, explain the item you are not sure about and, if you wish, ask for evidence of the charge such as a copy of the charge slip. Do not send in your copy of a sales slip or other documents unless you have a duplicate copy for your records.

      iii) The dollar amount of the suspected error.

      iv) Any other information (such as your address) which you think will help OrthoSport OC Physical Therapy to identify you or the reason for your complaint or inquiry.

   b) Send your billing error notice to:

      OrthoSport OC Physical Therapy
      26522 La Alameda, Suite 100
      Mission Viejo, CA 92691

      Mail it as soon as you can, but in any case, early enough to reach OrthoSport OC Physical Therapy within 60 days after the bill was mailed to you

2) OrthoSport OC Physical Therapy must acknowledge all letters pointing out possible errors within 30 days of receipt, unless we are able to correct your bill during that 30 days. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill was correct. Once OrthoSport OC Physical Therapy has explained the bill, we have no further obligation to you even though you still believe that there is an error, except as provided in paragraph 5 below.

3) After we have been notified, neither OrthoSport OC Physical Therapy nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount tin dispute, but periodic statements may be sent to you, and the disputed amount can be applied against your credit limit. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. *However, you remain obligated to pay the parts of your bill not in the dispute.*

4) If it is determined that OrthoSport OC Physical Therapy has made a mistake on your bill, you will not have to pay any finance charges on the disputed amount. If it turns out that OrthoSport OC Physical Therapy has not made an error, you may have to pay finance charges on the amount in dispute, and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct, OrthoSport OC Physical Therapy must send you a written notification of what you owe; and if it is determined that we did make a mistake in billing the disputed amount, you must be given time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged to you.

5) If OrthoSport OC Physical Therapy's explanation does not satisfy you and you notify us *in writing* within 10 days after you receive our explanation that you still refuse to pay the disputed amount, we may report you the credit bureaus and other creditors and may pursue regular collection procedures, But we must also report that you think you do not owe the money, and we must let you know to whom such reports were made. Once the matter has been settled between you and OrthoSport OC Physical Therapy, we must notify those to whom we reported you as delinquent of the subsequent resolution.

6) If OrthoSport OC Physical Therapy does not follow these rules, we are not allowed to collect the first $50 of the disputed amount and finance charges, even if the bill turns out to be correct.

I have read and understand the above stated financial, office, and privacy policies.

Patient Signature: ______________________________ Date: ____________________

Print Name: ______________________________

Responsible Party (if different): ______________________________ Relation: ____________________

OrthoSport OC Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

Federal law requires that we obtain your written acknowledgment of receipt of the Notice of Privacy Practices.

I, ____, have received a copy of this
(Please Print Patient's Name)

office's Notice of Privacy Practices.

____
(Patient's Signature)

____
(Patient's Date of Birth)

____
(Patient's Legal Representative / Parent) (Print) (If Patient Unable to Sign or Is a Minor)

____
(Patient's Legal Representative / Parent) (Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please Specify)

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