



## **PATIENT INFORMATION FORM**

Our registration form will need to be completed prior to scheduling an appointment

Birthdate: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Sex: ☐ Male ☐ Female ☐ Other Marital Status: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Appointment reminders via text? ☐ Yes ☐ No (rates may apply) Phone Carrier: \_\_\_\_\_

Okay to leave a confidential message? ☐ Yes ☐ No

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Notice of Privacy Practices (HIPAA)**: You understand we will use & disclose your personal health information to provide, coordinate and administer your healthcare, to obtain payment from your insurance, to evaluate the quality of services provided, and for any administrative operations related to treatment, payment, and public health or law requirements. A copy of the Notice of Patient Information Practices is posted at the front desk and a copy can be made available to you at your request.

Please list anyone you authorize the release of your HIPAA protected information (if none, leave blank):

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Is this injury caused by an auto or a work accident? ☐ Yes ☐ No

If neither, please indicate how: \_\_\_\_\_

Is there an attorney involved? ☐ Yes ☐ No

If yes; Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pain Level: 1 2 3 4 5 6 7 8 9 10

Recent falls? \_\_\_\_\_ If yes, when: \_\_\_\_\_ Recent surgery? \_\_\_\_\_ If yes, when: \_\_\_\_\_

Current medication list:

\_\_\_\_\_

Have you had Physical Therapy for this injury? \_\_\_\_\_ If yes, where: \_\_\_\_\_

Therapy Goals: \_\_\_\_\_

## **Consent, Financial and Office Policies:**

### **Medicare Insurance Guidelines:**

Medicare deductible for 2025 is \$257, commercial insurance deductible varies. If the deductible has not been met, you may have an outstanding balance once claims are processed.

Medicare covers 80% of services and 20% will automatically cross over to your supplemental plan (note: *we do not bill secondary/supplemental insurance*). If you do not have a supplemental plan, you will be responsible for a payment of \$20 towards the 20% co-insurance due at the time of service. We are not contracted with BC, BS, HealthNet and varies other carriers.

*\*We do not guarantee payment from most supplemental plans, any denied amount will fall under the patient's responsibility*

Progress evaluations are required every 10th session (does not require your physician signature). A recertification appointment is required at the end of your treatment duration to determine your next plan of care (ex: *discharge or continuation*).

*\*Recertification report is required to be signed by your referring physician to authorize continuing treatment. No further appointment can be made until signed.*

Medicare will NOT cover outpatient therapy if you are enrolled in home health for any services, you are required to notify our office if you are enrolled or become enrolled with home health.  
*A discharged summary is required prior to scheduling.*

Initial: \_\_\_\_\_

### **HMO Insurance Guidelines:**

HMO plans require prior authorization; we cannot schedule pending authorization. If you decide to schedule beyond authorization as a self-pay patient, we cannot bill insurance once it is authorized since the appointments you would have had as a self-pay patient would have consisted of the flat discounted rate and would not have any billing codes attached.

If you have a co-payment with your HMO plan, payment will be due at the time of service.

Initial: \_\_\_\_\_

### **Workers Compensation and VA Programs:**

Prior authorization is required. We cannot schedule/hold any appointments pending authorization. Your physician must request authorization directly through your insurance.

Initial: \_\_\_\_\_

### **Motor Vehicle Accident (Med-Pay):**

We DO NOT accept third party insurance. If you have Med-Pay available with your auto insurance coverage, we will bill them directly (*NOTE: it is your responsibility to track your allowed amount to avoid denials that will fall into your responsibility*). If you do not have Med-Pay available and want to use your personal insurance (within network), you will need to sign a patient responsibility form for any denials related to your MVA.

Initial: \_\_\_\_\_

### **Self-Pay Patients:**

Our discounted self-pay rates for our standard half-hour sessions are **\$150 for evaluation** and **\$100 for each follow-up** (not billing insurance). We can provide you with a ledger to submit to your insurance carrier for reimbursement if you choose to (*we cannot guarantee reimbursement or provide modification to our ledgers for insurance purposes*). We require a credit card on file for all out-of-pocket costs. By signing below, you authorize PTI to run your card at the time of service.

Initial: \_\_\_\_\_

**Patient Information:** If there are any changes made to your insurance, address, phone number, or email address, please inform us so we may update your file. Outdated contact and insurance information can result in your account falling into collections and/or claim denials.

**Treatment:** We are only allowed to treat the diagnosis/body part as stated on your physician's referral/insurance authorization.

**Medical Records** If you need to obtain a copy of your records, please submit a request in writing to our medical records processor. There is a minimum processing fee of \$0.25 per page plus \$7 admin fee for every 15 minutes payable at the time your request is processed.

**Completion of Forms:** If you request a letter to be written or a form to be signed/completed, we ask to allow time for us to process as some requests are detailed and required us to review prior to completing. A fee will apply and must be paid in full at the time of the request.

**Cancellation Policy:** We have a strict no show/late cancellation policy. You are responsible for your own appointments. As a courtesy, we offer appointment printouts or courtesy reminders via texts or emails. Please *NOTE: you cannot reply to email or text reminders, you must call in (voicemail is available after hours)*. If you do not arrive for a scheduled appointment and/or cancel in less than 24 hours, you will be subjected to a **\$100 fee** paid directly by you, not your insurance company. To keep ongoing appointments, late cancellation fees are to be paid at the time of occurrence. All communication regarding scheduling/rescheduling or cancellation must be done via the front office *only (failure to do so can result in late cancellation)*. If you are under workers comp or a VA program, you are not subjected to the fee, but on the second late cancellation or no show we permanently discharge you from our clinic for one year.

**Copayments/Fees:** All payments (*copayment, out of pocket, self-pay*) are due at the time of service. If you do not pay at the time of service, a **\$25 billing fee** will be added to your balance on each statement mailed out to you. If your insurance denies any claim/procedures or does not compensate us within 90 days, the balance on your account will become your responsibility.

**Bad Debt:** Patients who have bad debts or never satisfied their payment obligations for prior episodes of care will be required to pay their bad debt obligation before scheduling future appointments. In addition, you may be required to pay your deductible and any co-insurance at the time of service. Patients who were granted bankruptcy may not be allowed to schedule future appointments.

**Past Due Balances** - Accounts that are delinquent over 90 days will be internally submitted to collections. If we must send your account to collections, there will be an extra fee added to your balance, and all future appointments will be cancelled. Once in collections we are unable to reduce/void/adjust any fees.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

**Third Party Insurance:** Our office is not contracted to bill third-party such as motor vehicle insurance, LIENS, Medi-Cal, and various commercial insurances. If you are covered by any of these types of insurance, you will be charged our out-of-pocket rates.

**Returned Check Fees:** A **\$50 fee** will be charged for any bounced check. We also have a **\$75 charge back fee**. You will be required to pay any remaining balance with a credit card.

**Final Cost of Service:** You understand that PTI representatives can only estimate potential costs and cannot guarantee final costs until all claims have been processed by your insurance carrier. You further understand that final costs are determined by your insurance carrier, including coverage and authorization limitations, and that insurance payment is not a guarantee. Payment is subject to the terms, conditions, and coverage specifics of your individual plan. Estimates provided are based on the information available from your insurance carrier at the time the estimate is given. If your insurance processes a claim or adjusts payments based on their policies or coding interpretations and this results in a billing discrepancy, this is not the responsibility of PTI. Final billing may differ from initial estimates based on actual processing by your insurance carrier.

**Discharge of a Patient:** You understand that PTI has the right to discharge any patient from this practice at any time for various reasons, including but not limited to failure to abide by PTI financial policies, non-compliance of recommended treatment plans, drug-seeking activity and any abuse of PTI providers and staff. If this occurs, you understand that your medical records will be released to a physician or healthcare facility of your choice only after an appropriately signed documentation is received by PTI. You further understand that once discharged from PTI, you will not be allowed to return as a patient of PTI in the future.

**Consent to Treat Minor:** If the patient is a minor, I, the parent/guardian, consent to the direct care and treatment of symptoms of said patient, in the parent or legal guardian's presence and absence.

**Consent to Treat:** You consent and authorize Physical Therapy Innovations to provide and perform therapy treatment services as appropriate for your diagnosis and symptoms. You also authorize your insurance benefits to be paid directly and mailed to: **PTI at 425 Kearney Street El Cerrito Ca. 94530**. If my policy prohibits direct payment to the health provider, then I hereby also instruct my insurance company to make the check out to me but mail it in care of Physical Therapy Innovations, Inc

By typing my name below, I acknowledge and agree with all the above, I understand and agree that your consent, financial and office policies remain in effect until you decide to revoke them in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_