AVANTI
PHYSICAL THERAPY & SPORTS MEDICINE

Patient Information Sheet

Welcome to our Office...

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed Divorced

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Emergency Contact:

Emergency Telephone#: (_____) _____

Employer Name:

Occupation:

Ref Dr:

Ref Dr's Add / City / State / Zip

Ref Dr NPI #

Primary Care Physician:

PCP Add / City / State / Zip

PCP NPI #

Primary Insurance Company Information:

Policy Holder First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____

Policy Holders Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $ _____

Referral Required: ☐ **Yes** ☐ **No**

Secondary Insurance Company Information:

Policy First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____

Policy Holders Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $ _____

Referral Required: ☐ **Yes** ☐ **No**

FINANCIAL POLICY

I DO HEREBY assign all insurance benefits to be paid directly to AVANTI PHYSICAL THERAPY & SPORTS MEDICINE for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me by AVANTI PHYSICAL THERAPY & SPORTS MEDICINE. I further authorize AVANTI PHYSICAL THERAPY & SPORTS MEDICINE to release information required regarding the course of my treatment for the purpose of evaluating and administering claims for benefits. I understand that I am responsible for services not covered by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your plan's guidelines. Should this account become delinquent, I understand that I am responsible for any/all legal fees, court costs, interest accrued, and collections charges involved as a result of any collection activity.

The Practice accepts persional checks. In the event that a check "bounces" (i.e. insufficient funds exist to cover the check), a fee of $25 will be applied.

Patient/Gaurdian's signature: _____ **Date:** _____

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FINANCIAL AGREEMENT

We would like to take a moment to welcome you to AVANTI Physical Therapy & Sports Medicine and to assure you that you will be receiving the very best care available.

To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled. Charges for the treatment in this office are due and payable at the time the service is rendered. However, if this is inconvenient for you, we will be glad to set up a payment plan to assist you while you are under current care in our office.

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claims.

PAYMENT PLAN

_____ **CASH**: I agree to make a per visit payment. I agree to pay any outstanding balance within one month after termination of my care. I further agree to pay any interest charge of 18% (annum) for any balance that is over 30 days past due. **CASH PAY PATIENTS FLAT RATES INCLUDE EVALUATION/FOLLOW-UP; <u>DOES NOT INCLUDE PILATES SESSIONS</u>.**

_____ **INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. If my insurance carrier sends payment directly to me for the services rendered in this office, I agree to send or bring those payments to this office upon receipt. I agree to pay my yearly deductible amount, co-payment and 100% of my co-insurance portion per visit.

_____**MEDICARE:** I understand that my Medicare insurance policy only covers 80% of the allowed charges for physical therapy procedures performed by a Physical Therapist, once my deductible has been met. I agree to be personally responsible for payment of my deductible amount, my co-insurance percentage for covered services and for all non-covered services. You must NOT currently be receiving Medicare covered home health care in order for Medicare to pay for this outpatient service. This includes home health nursing, home health aide, home health therapy. Outpatient Physical Therapy Benefit Threshold is $2,410 (~18 visits). You may qualify for coverage beyond that amount IF MEDICALLY NECESSARY.

A **$25 fee** will be applied for any appointment that is **NOT ATTENDED** or **CANCELLED** within 24 hours of your scheduled appointment. This fee will need to be paid at your next scheduled appointment.

I further understand that if I suspend or terminate my care with this office, my portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to me, and I, ultimately will be personally responsible for payment regardless of my insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____

Patient/ Responsible Party's Signature Date

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PHYSICAL THERAPY & SPORTS MEDICINE

Communicating With You

In order to effectively communicate with you about your medical information, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voicemail.**

Please check all boxes that give AVANTI Physical Therapy & Sports Medicine permission to use for your communication:

◯ You may contact me by telephone	Phone Number: _____
◯ You may leave a message / voicemail	Phone Number: _____
◯ You may contact me by mail	
◯ You may contact me through email	E-mail: _____

Please list any persons you would like to have access to your billing, appointment or health information, such as your spouse, caretaker or other family member.

Name/Phone Number	Relationship	Options
1.		◯ Billing Information ◯ Appointment Information ◯ Medical / Health Information
2.		◯ Billing Information ◯ Appointment Information ◯ Medical / Health Information
3.		◯ Billing Information ◯ Appointment Information ◯ Medical / Health Information
4.		◯ Billing Information ◯ Appointment Information ◯ Medical / Health Information

This request supersedes any prior request for communication of information that I may have made.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

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PHYSICAL THERAPY & SPORTS MEDICINE

Assignment of Benefits Form & Acknowledgement of Personal Responsibility

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to AVANTI Physical Therapy & Sports Medicine for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize AVANTI Physical Therapy & Sports Medicine to: (1) release any information necessary to insurance carriers and/or health practitioners regarding my injury/diagnosis and treatments; (2) process insurance claims generated in the course of evaluation or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested physical therapy services from AVANTI Physical Therapy & Sports Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

ERISA Authorization
I hereby designate, authorize, and convey to AVANTI Physical Therapy & Sports Medicine to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031 (b)(4) with respect to any healthcare expense incurred as a result of the services I received from AVANTI Physical Therapy & Sports Medicine and, to the extend permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Provider Information
AVANTI Physical Therapy & Sports Medicine
28382 S Western Avenue
Rancho Palos Verdes, CA 90275
(310) 526-8599 fax (424) 424-0441

_____
Print Patient/Responsible Party Name

_____ _____
Patient/Responsible Party Signature Date

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PHYSICAL THERAPY & SPORTS MEDICINE

INFORMED CONSENT TO PHYSICAL THERAPY TREATMENT

I hereby request and consent to the performance of conservative non-invasive treatment to the joints and soft tissue, including various modes of physical therapy, on me (or on the patient names below, for whom I am legally responsible) by the Licensed Physical Therapist/Physical Therapy Assistant who now or in the future work at AVANTI Physical Therapy & Sports Medicine.

I have had an opportunity to discuss with the Licensed Physical Therapist/Physical Therapy Assistant or clinic personnel the nature and purpose of Physical Therapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the providers to anticipate and explain all risks and complications, and I wish to rely upon the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known to him or her, is in my best interest.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my provider and such other persons of the provider's choosing in accordance with Federal and State laws and regulations.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named-procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent/Guardian
(If patient is a minor)

Date

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____

Patient Name

_____ _____

Signature of Patient/Guardian Date

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Intake Form

Check if you have or had any of the following conditions:

- ○ Asthma
- ○ Arthritis
- ○ Blood Transfusions
- ○ Bowel/Bladder Issues
- ○ Fractures
- ○ Hepatitis
- ○ Shingles
- ○ High Cholesterol
- ○ Hypoglycemia
- ○ Other: _____
- ○ Depression
- ○ Liver problems: _____
- ○ Polio
- ○ Thyroid problems: _____
- ○ Allergies
- ○ Cancer: _____
- ○ Diabetes
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Heart Attack
- ○ Stroke
- ○ Kidney problems: _____
- ○ Osteoporosis
- ○ Headaches
- ○ Dizziness
- ○ Seizures
- ○ Hernia
- ○ Recent falls

Height: _____ Weight: _____

Have you **recently** experienced: Check those that apply:

___ Unexplained weight loss ___ Nausea/vomiting ___ Fever/chills/sweats

___ Excessive fatigue ___ Excessive weakness ___ Numbness or tingling

Do you have any metal implants (joint replacements, plates, rods, screws, stents, etc.)? ___ yes ___ no

Are you currently or have you taken steroid medications? ___ yes ___ no

Are you currently taking anti-coagulant medications (e.g. Coumadin)? ___ yes ___ no

Do you have a pacemaker or IAD (internal automated defibrillator)? ___ yes ___no

For Women: Are you pregnant? ___ yes ___ no

Previous Surgeries/Date: _____

_____

Previous Injuries/Date: _____

_____

List any medications/supplements you are currently taking, including dosage: _____

_____

Please check any diagnostic tests done for this condition:

- ○ X-ray/date: _____ Results: _____
- ○ MRI/date: _____ Results: _____
- ○ CT/date: _____ Results: _____
- ○ EMG (nerve test) Results: _____
- ○ Other _____

Occupation: _____

Employment Status (Please Circle): Full duty, Modified Duty, Retired, Unemployed, Disability

How and when did the symptoms begin? _____

Is this from a recent automobile accident Y / N If yes, date: _____

Is this due to a traumatic event/injury? _____

Did this occur on the job? Y / N If yes, date: _____

Are your symptoms? (Please Circle): Improving Worsening Unchanging

Where is the location of your pain? _____

Are there radiating symptoms? _____

Is your sleep disturbed? Y / N

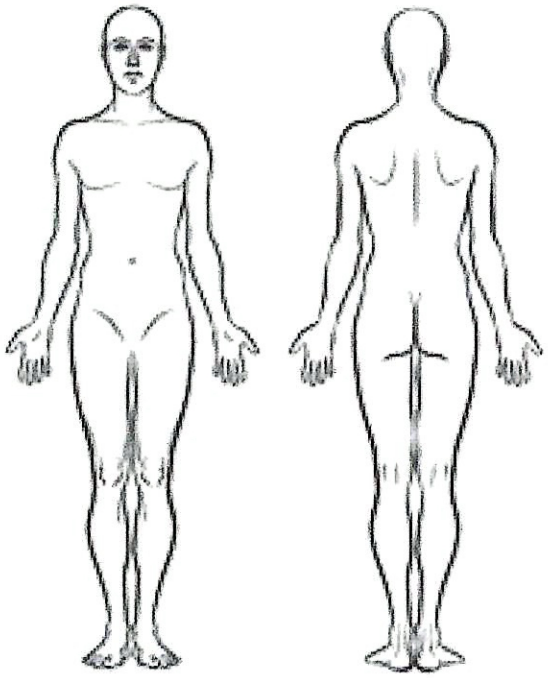
Is there any history of previous injury to the same area? _____

Have you ever had previous treatment for this condition? _____

What goals do you have for treatment? _____

Better	Worse		Better	Worse	
		Rest/Sleep			Meal preparation
		Lying on your back			Eating
		Lying on your side left right			Coughing/Sneezing
		Lying on your stomach			Yawning
		Rolling over			Housework
		Sitting			Vacuuming
		Rising from sitting			Yardwork
		Standing			Deskwork/Computer/Mouse
		Walking			Childcare List Limitations:
		Change in position			
		Reaching forward			
		Reaching behind			Driving
		Reaching overhead			Getting in / out of car
		Lifting			Sports/Recreation
		Dressing			Stairs
		Grooming			Medication
		Bending			
		Squatting			Other Specify:

Mark the location of your symptoms on the figures below with an X. Mark and label with 0 any areas where you experience tingling, numbness or burning.



On the PAIN INTENSITY scale below, circle the level of your primary pain where level 1 is slightly uncomfortable, and level 10 is unbearable.

(LEAST PAIN) 1 2 3 4 5 6 7 8 9 10 (MOST PAIN)

What type of symptoms do you experience? _____ Sharp _____ Dull Ache _____ Radiation/Shooting

How frequent are your symptoms? _____ Constant _____Intermittent

Are your symptoms worse in the: _____AM _____ PM